

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

VR A15 (4)  
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R # 2 Hagerstown</u> 10 yrs.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R # 2 Hagerstown</u> 21-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R # 2 Hagerstown</u>					d. STREET ADDRESS <u>R # 2 Hagerstown</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gertrude Emma Airesman</u>					4. DATE OF DEATH Month Day Year <u>February 5 1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1882</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flowers</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Milford, Kansas</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Henry Bartell</u>					14. MOTHER'S MAIDEN NAME <u>Barbara Faidley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>172-09-5617 A</u>		17. INFORMANT Address <u>Mr. Harry D. Airesman R # 2 Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u> <u>5 years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-4</u> , 19 <u>66</u> , to <u>2-5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-5</u> , 19 <u>66</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. E. W. Ditto, Jr.</u> M.D.								22b. DATE SIGNED <u>2-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>								22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>		
24. FUNERAL DIRECTOR <u>Wm. G. Host</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				DATE <u>FEB 10 1966</u>					

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02890

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02868

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN lb <b>1 1/2 MOS.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>237 S. MULBERRY STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>DAVID</b> Last <b>ALLEN</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>23</b> Year <b>1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 4, 1882</b>	
9. AGE (In years last birthday) <b>83 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MILLER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ORGAN FACTORY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>DEANSBORO, N. YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM ALLEN</b>		14. MOTHER'S MAIDEN NAME <b>MARY BRODIE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>214-09-3049</b>		17. INFORMANT <b>MRS. LOUISE ALLEN</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal carcinoma of the lung</b> <b>163 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/2</b> , 1966, to <b>2/23</b> , 1966, that (I) (we) last saw the deceased alive on <b>2/23</b> , 1966, and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard N. Weeks</i>				22b. DATE SIGNED <b>2/23/1966</b>		22c. PHYSICIAN'S NAME (Type) <b>HOWARD N. WEEKS M.D.</b>	
22d. ADDRESS <b>580 NORTHERN AVE. HAGERSTOWN, MD.</b>				22e. REC'D BY REGISTRAR <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 25, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Charles Judge</i>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02891					02869					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>47 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clear Spring, Md.</u> d. STREET ADDRESS <u>Cumberland St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edith</u> First Middle Last <u>May</u> 4. DATE OF DEATH <u>Feb. 8</u> Month Day Year <u>19 66</u>			5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/19/70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home duties</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Clear Spring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		9. AGE (in years last birthday) <u>95</u> yrs.	
13. FATHER'S NAME <u>Martin Luther Beard</u>					14. MOTHER'S MAIDEN NAME <u>Mary Feidt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>220-44-3752</u>		17. INFORMANT <u>Benjimen Solliday</u> Address <u>Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia acute</u> <u>443+</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>20 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>December 19 65</u> , <u>Feb. 08</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>February 07 1966</u> , and that death occurred at <u>4:35AM</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Archie Robert Cohen</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>					22b. DATE SIGNED <u>Feb 09, 1966</u> 22d. ADDRESS <u>Clear Spring, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>St. Paul, Wash. Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Margaret Rowland</u> ADDRESS <u>Clear Spring, Md.</u>					25. REC'D BY REGISTRAR <u>FEB 14 1966</u> DATE <u>Charles Judge</u>					

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VR A15 (4)  
 20M 5-63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02892		Item 9 Film 5774 2/26/66 md				02870					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIBERTYTOWN</u> <u>RURAL 10-2</u>				d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fahrney Keedy Memorial Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Edwin BAKER</u>						4. DATE OF DEATH Month Day Year <u>Feb. 19 1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5 1874</u>		9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ALLERGY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William F. Baker</u>						14. MOTHER'S MAIDEN NAME <u>Mary T. Case</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MD R2</u> <u>MRS CARROLL WARFIELD, UNION BRIDGE</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. DUE TO (c) }											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10 1966</u> to <u>Feb 19 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 18 1966</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>G. W. Hedan</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Boonsboro, Md.</u>		22b. DATE SIGNED <u>2/19/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. W. Hedan</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOCUST GROVE</u>		23d. LOCATION (City, town or county) (State) <u>FREDERICK CO MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler &amp; Sons Libertytown, Md</u>						25a. REC'D BY REGISTRAR DATE <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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STANDARD OF EXCELLENCE

1152311





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 1</u> c. LENGTH OF STAY IN 1b <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clear Spring, Md.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 1</u> d. STREET ADDRESS <u>Clear Spring, Md.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bernard Issac Barnhart</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov. 15, 1892</u> <b>9. AGE</b> (In years last birthday) <u>73</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.						<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Fulton Co. Pa.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Stillwell Barnhart</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> <b>16. SOCIAL SECURITY NO.</b> <u>212-38-9154</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizebeth Mann</u> <b>17. INFORMANT</b> <u>Mrs Lola Barnhart</u> <b>Address</b> <u>Rd. 1, Clear Spring Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with generalized metastases</u> (b) <u>metastases</u> (c) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 yrs.</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>11-19, 1954</u> Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-19, 1954</u> <b>to</b> <u>2-6, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12-6, 1965</u> , <b>and that death occurred at</b> <u>8:00 P.M.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Charles F. Hess</u> <b>22c. PHYSICIAN'S NAME (Type)</b>						<b>22b. DATE SIGNED</b> <u>2-8-66</u> <b>22d. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>2/9/66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Broadfording Cemetery</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Broadfording, Md.</u>											
<b>24. FUNERAL DIRECTOR</b> <u>Margaret Rowland</u> <b>ADDRESS</b> <u>Clear Spring, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>FEB 14 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

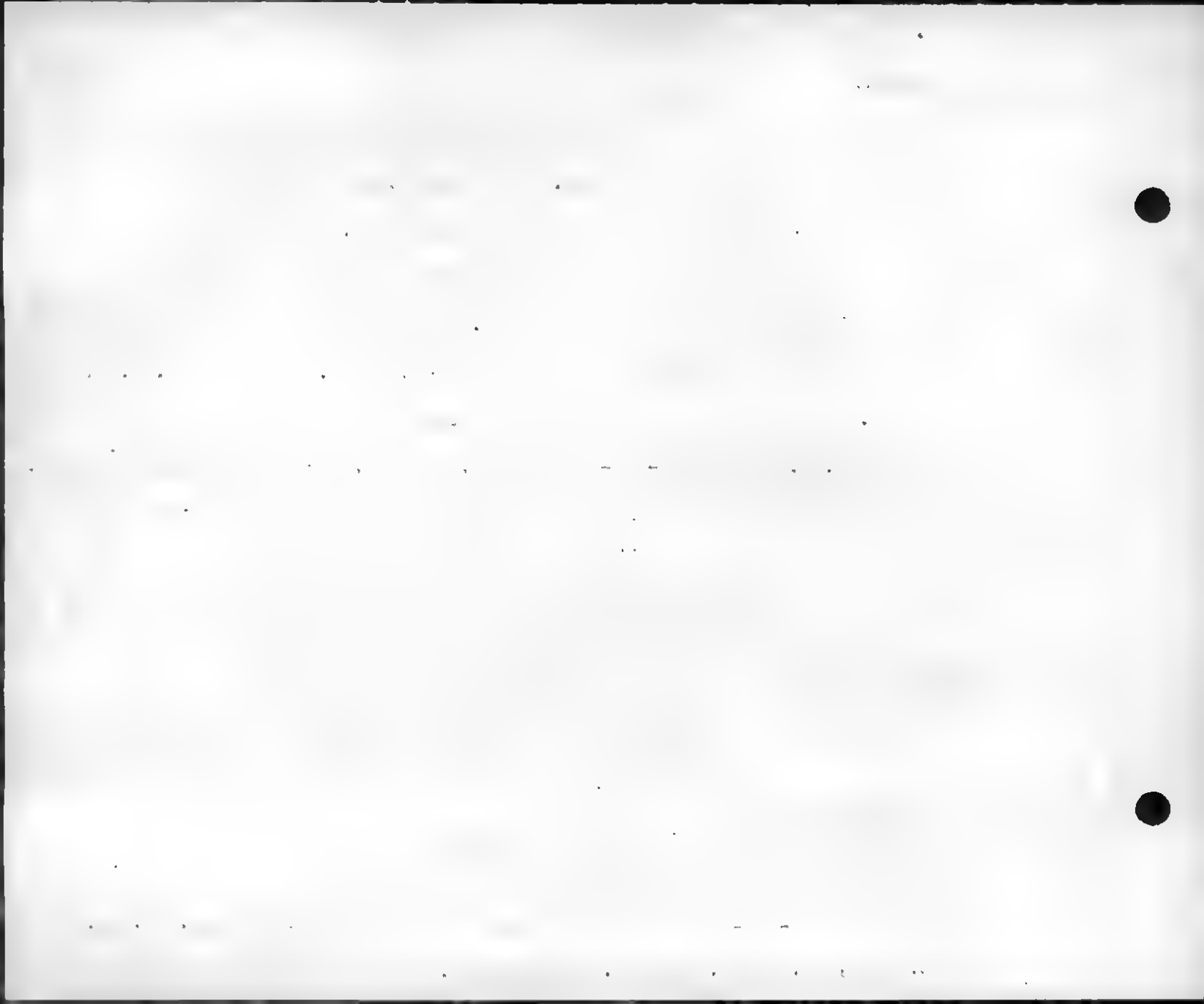
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02872

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>13 Yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>29 High St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>Clyde Victor Barnhart</b>				4 DATE OF DEATH Month Day Year <b>February 23, 19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1922</b>		9. AGE (In years last birthday) <b>44 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min <b>1 8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>Millstone, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Walter H. Barnhart</b>				14. MOTHER'S MAIDEN NAME <b>Daisy Manning</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W. W. Two</b>		16. SOCIAL SECURITY NO. <b>216-14-5756</b>		17. INFORMANT <b>Mrs. Doris H. Barnhart, 29 High St. Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage, Massive</b> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Disease</b> DUE TO (c) <b>Nephrosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 12, 1957</b> to <b>Feb 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 23, 1966</b> , and that death occurred at <b>330 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Robert V. H. Campbell</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. H. Campbell</b>				22d. <input type="checkbox"/> DRESS <b>HAGERSTOWN MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-26-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Orchard Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hancock, Wash. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



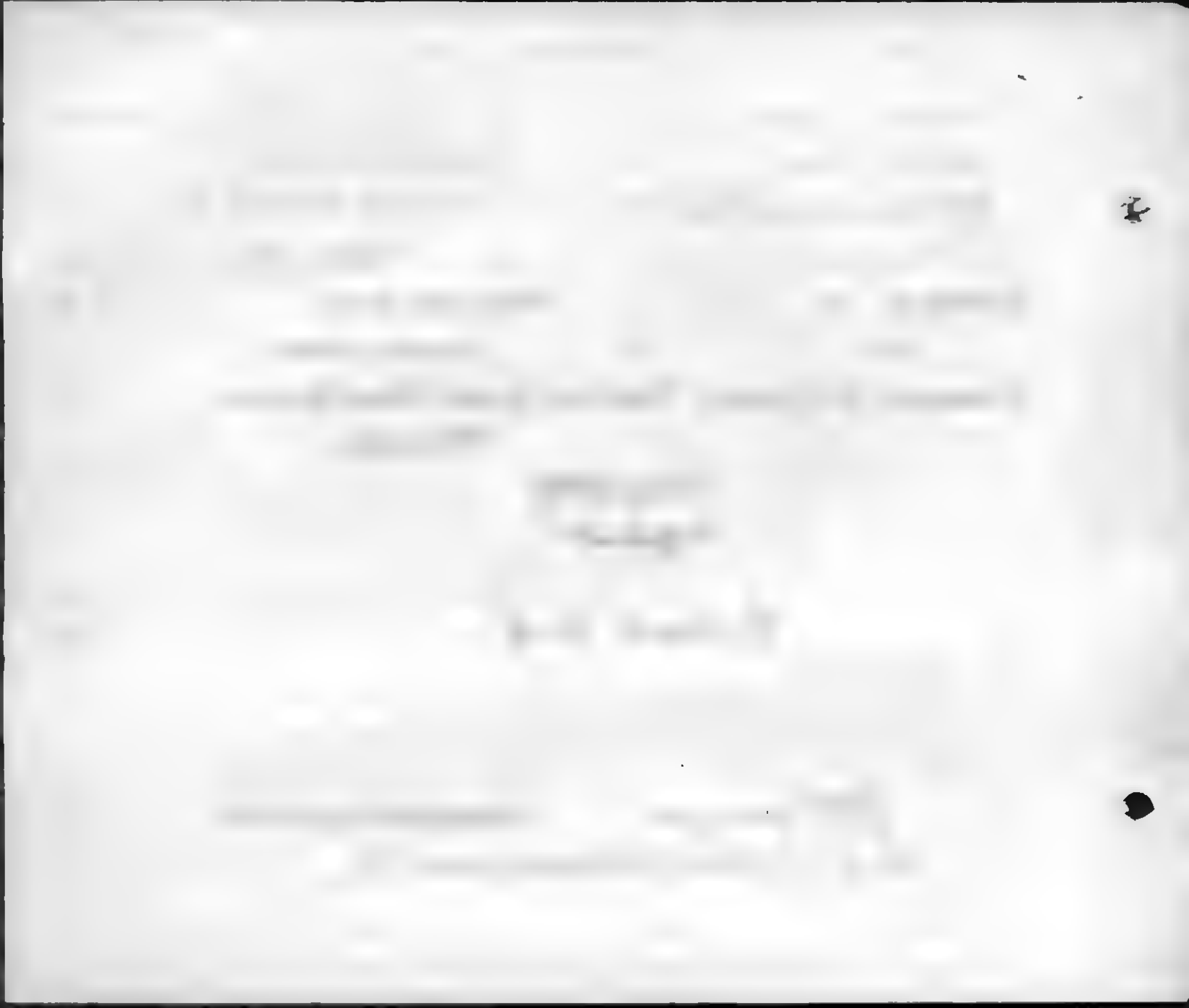
CERTIFICATE OF DEATH

Reg. Dist. No.

028735-4810

02895

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1104 S. POTOMAC ST.</b>	
3. NAME OF DECEASED (Type or print) <b>BABY GIRL BLACK</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 17, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>17</b> yrs
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CHARLES RICHARD MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>JUDY ANN BLACK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>MOTHER</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>7199</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephritis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prolapsed Cord</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>o. m.</b> <b>19</b> Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>J. D. Turco</b> M.D. <b>HAGERSTOWN, MD.</b>		PHYSICIAN'S NAME (Type) <b>DR. J. D. TURCO, HAGERSTOWN, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2/21/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WASH. CO. Hosp.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Schaffer, adm. Wash Co Hosp</b>		24. REC'D BY REGISTRAR - <b>MAR 4 1966</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	



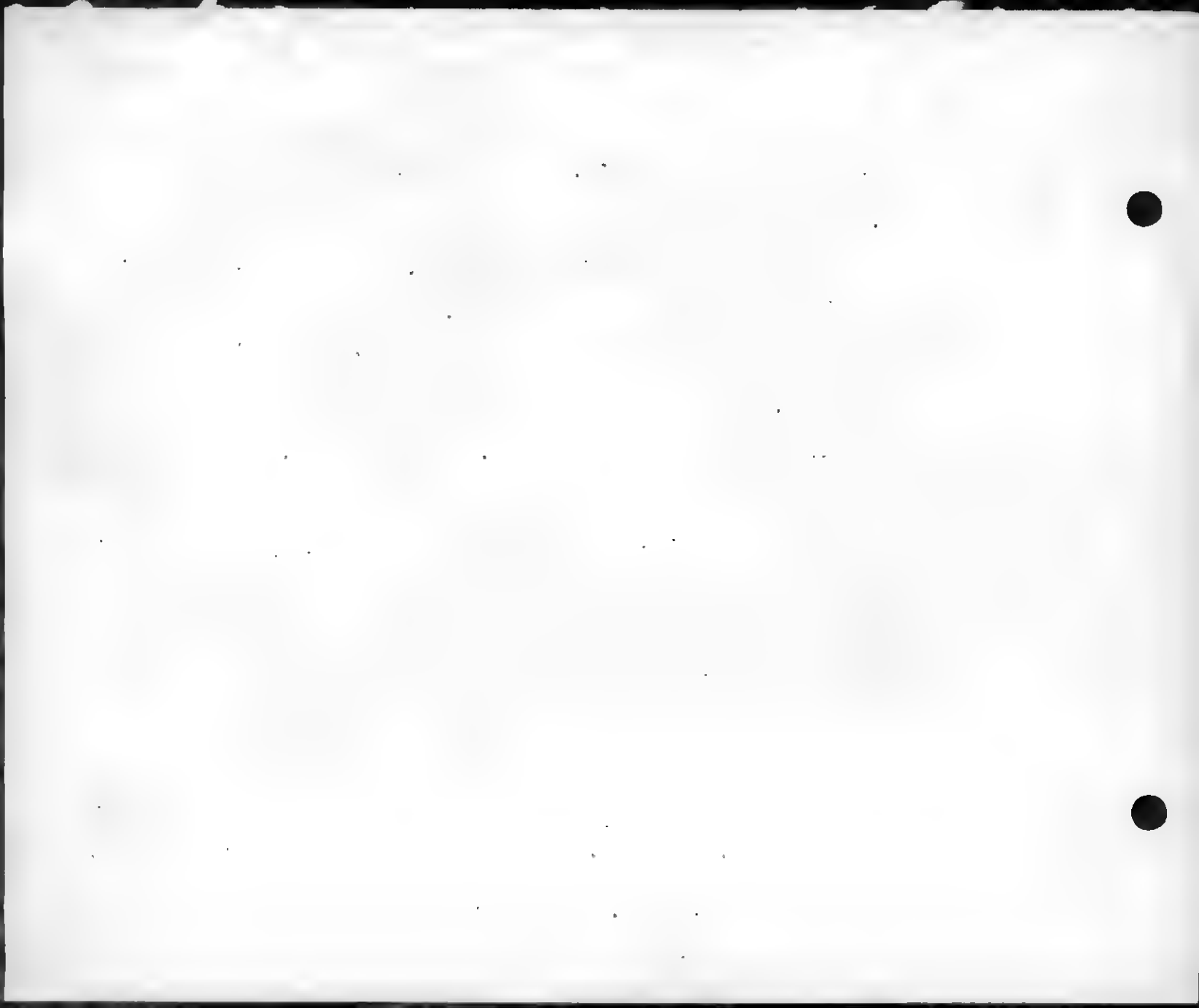


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TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02896		02874	
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
c. LENGTH OF STAY IN 1b <b>2 MOS.</b>		d. STREET ADDRESS <b>138 N. POTOMAC STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROSE ETTA SMITH BOLINGER</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 14, 1908</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CLARKE CO., VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES T. ROWLAND</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE E. MORELAND</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. WILLIAM HART R.D. # 2 BERRYVILLE, VA.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer</b> DUE TO (b) <b>Carcinoma of esophagus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>9 mo - 15 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-11</b> , 19 <b>66</b> , to <b>death</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2-7</b> , 19 <b>66</b> , and that death occurred at <b>4:30 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert F. Keadle</b>		22b. DATE SIGNED <b>2/8/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT F. KEADLE, M.D.</b>		22d. ADDRESS <b>580 NORTHERN AVE., HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 10, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>SHARPSBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>CMFouga</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>	
ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

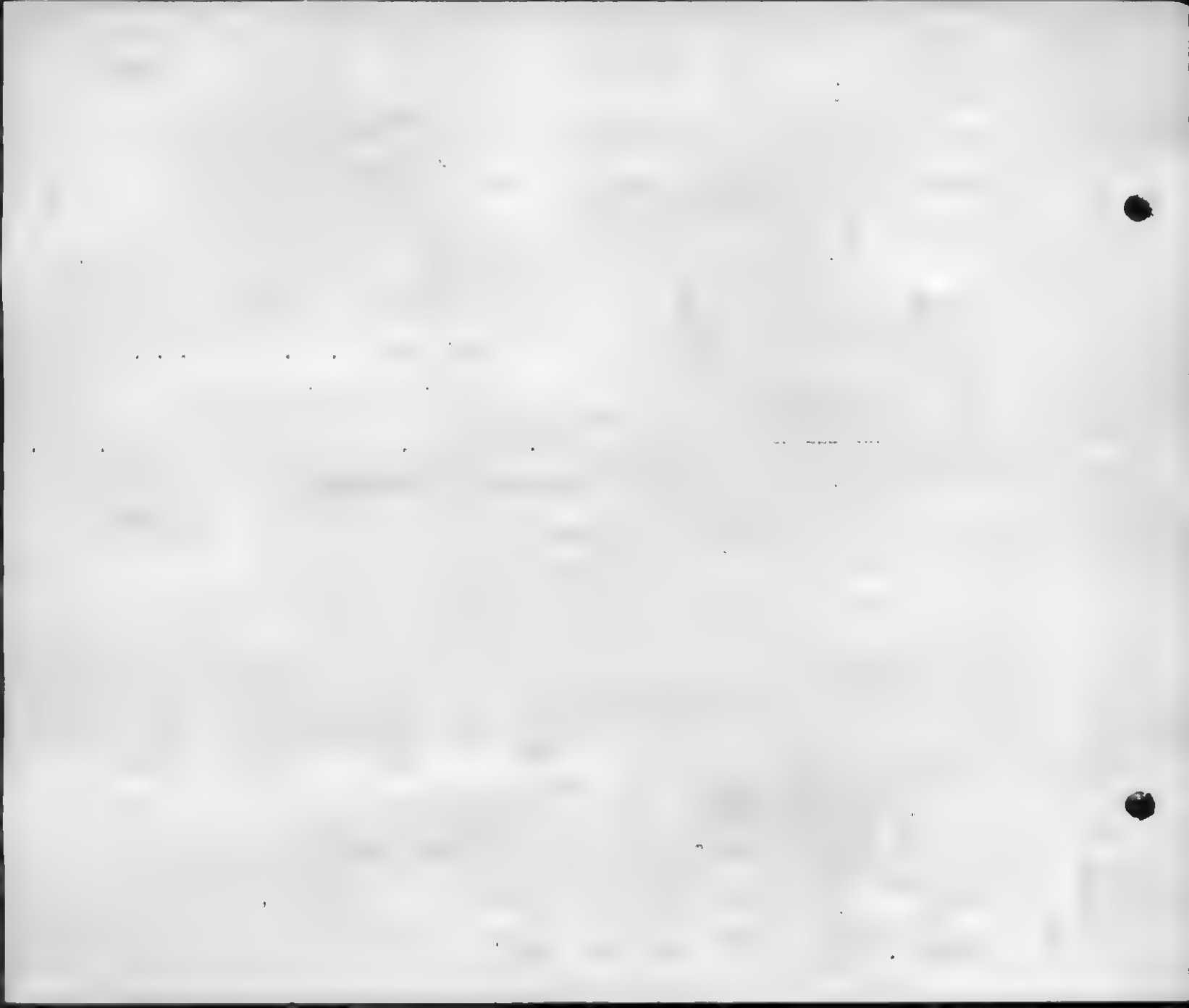
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02897

## CERTIFICATE OF DEATH

02875

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Washington</u> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) <b>a. STATE</b> <u>MARYLAND</u> <b>b. COUNTY</b> <u>FREDERICK</u>								
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>			<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>								
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>Fahrney-Keedy Memorial Home, Inc.</u>			<b>d. STREET ADDRESS</b> <u>101 Council St.</u>								
<b>3. NAME OF DECEASED</b> (Type or print) <u>Chrisse Byrd Dell BOWERS</u>			<b>4. DATE OF DEATH</b> <u>Feb. 9 1966</u>								
<b>5. SEX</b> <u>Female</u>			<b>6. COLOR OR RACE</b> <u>White</u>								
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>July 15 1875</u>								
<b>9. AGE</b> (In years last birthday) <u>90</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Mins.</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Mins.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Mins.										
<b>11. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>								
<b>13. FATHER'S NAME</b> <u>Martin Luther Firestone</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine Virginia Galle</u>								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>None</u>								
<b>17. INFORMANT</b> <u>Mr. Charles F. Bowers</u>			<b>Address</b> <u>18 West Third St. Fred. Md.</u>								
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <u>Cardio Vascular Disease</u> <u>Arteriosclerosis</u> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <u>5 yrs</u> <u>8 yrs</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 yrs</u> <u>8 yrs</u>						
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)											
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)							
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 10 1966</u> , <b>to</b> <u>Feb 9 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 9 1966</u> , <b>and his death occurred at</b> <u>1</u> M., <b>from the causes and on the date stated above</b>											
<b>22a. SIGNATURE</b> <u>G. W. Hevan</u>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>G. W. Hevan</u>											
<b>22d. ADDRESS</b> <u>Boonsboro, Md.</u>											
<b>22e. DATE SIGNED</b> <u>4/9/66</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/11/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mount Olivet Cemetery</u>							
<b>23d. LOCATION</b> (City, town or county) <u>Frederick, Maryland</u>		<b>(State)</b>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert E. Dailey &amp; Son</u>											
<b>ADDRESS</b> <u>Frederick, Maryland</u>											
<b>25a. REC'D BY REGISTRAR</b> <u>11 1966</u>											
<b>25b. REGISTRAR'S SIGNATURE</b> <u>in judge</u>											



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

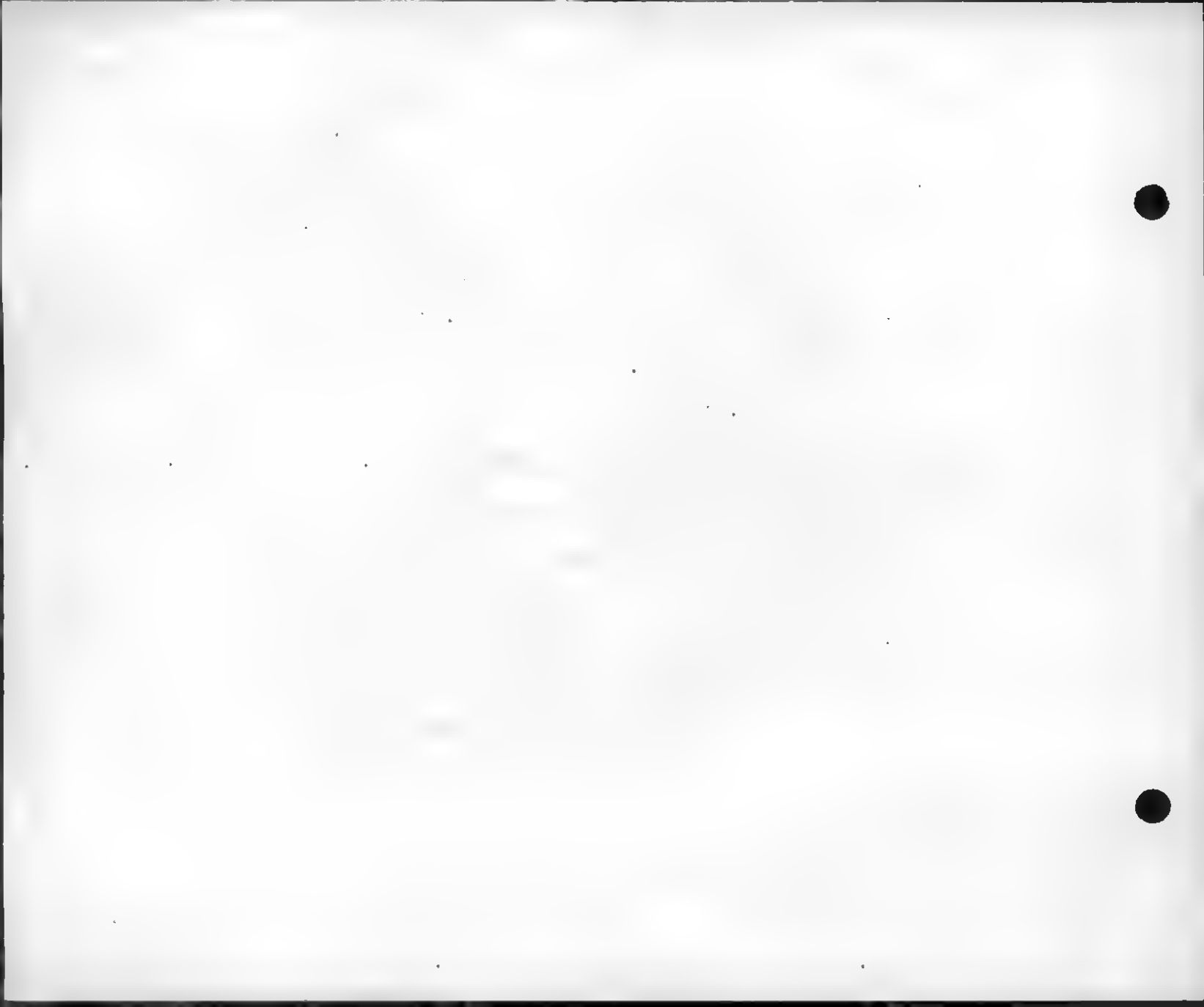
22093

02076

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c LENGTH OF STAY IN 1b <b>69 years</b>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d STREET ADDRESS <b>413 Sherwood Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>VIOLA</b> Last <b>BREWER</b>		4 DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 66</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Apr. 17, 1896</b>
9. AGE (In years last birthday) <b>69 yrs</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>general work</b>		10b KIND OF BUSINESS OR INDUSTRY <b>dept. store</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Hagerstown, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b></b>	
13 FATHER'S NAME <b>Charles E. Slick</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Shaffer</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>218-30-8703</b>	
17. INFORMANT <b>Charles E. Brewer, Hagerstown, Md.</b>		Address <b></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>1201</b> DUE TO (b) <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Arteriosclerotic Cardio. Dis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1-2 yrs</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension; Obesity.</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>59</b>	20f. (City or town) (County) (State) <b></b>
21. I certify that (I) (this hospital) attended the deceased from <b>5 June</b> , 19 <b>66</b> , to <b>20 Feb. 1966</b> , that (I) (we) last saw the deceased alive on <b>19 Feb. 1966</b> , and that death occurred at <b>1A</b> M, from causes and on the date stated above.			
22a SIGNATURE <b>Richard T. Binford</b> M.D.		22b DATE SIGNED <b>21 Feb. 66.</b>	
22c PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD</b>		22d ADDRESS <b>HAGERSTOWN, MD.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>2-22-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24 FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 24 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





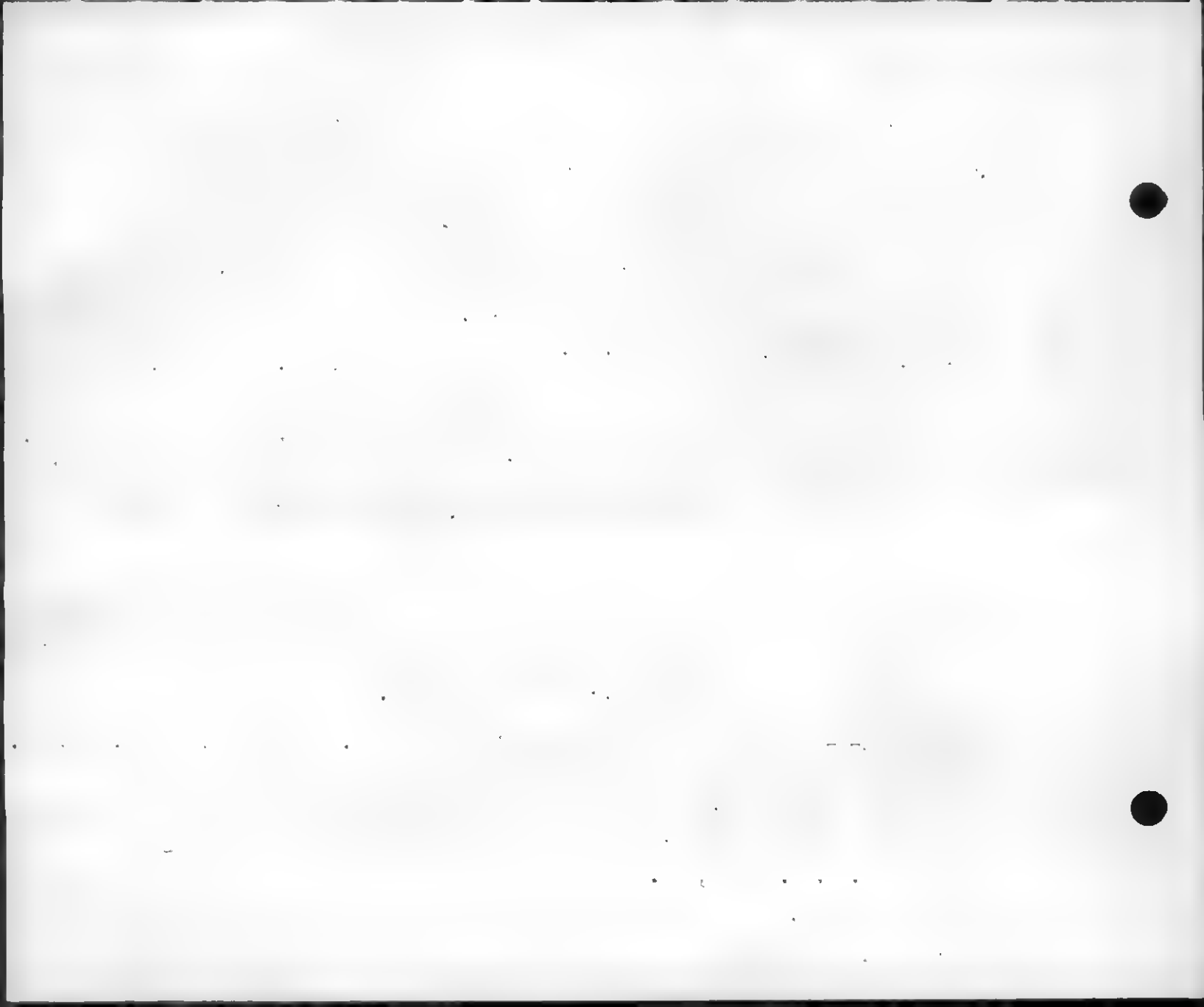
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday)	
10a. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. MOTHER'S MATEOEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound Of Chest ( Self Inflicted )</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>776 X</u> DUE TO (c) <u>776 X</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Self inflicted gunshot wound.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:55 p.m. 2-8-1966</u>		20d. INJURY OCCURRED <u>White at work</u> <input type="checkbox"/> <u>Not White at work</u> <input type="checkbox"/> <u>Taylor's Landing Rt. Sharpsburg, Washington, Md.</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>2-9-66</u>	
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR		ADDRESS	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE		<u>FEB 11 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

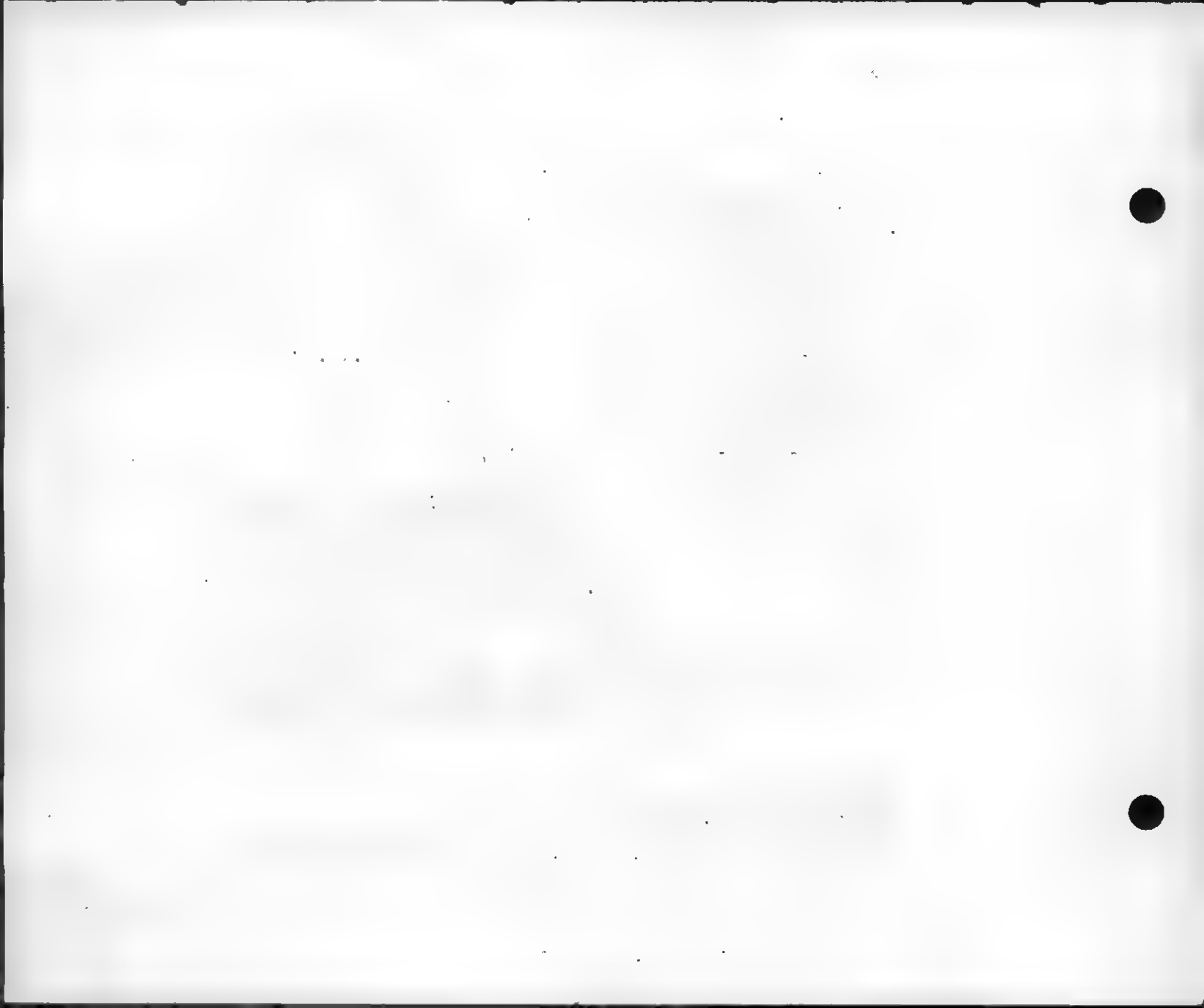
62900

CERTIFICATE OF DEATH

Item #2 3118 #4373 2/1 1966

02578

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>UNKNOWN</u> b. COUNTY <u>UNKNOWN</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 MONTHS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MD STATE HOSPITAL</u> <u>1500 PENN. AVE., HAGERSTOWN, MD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>BRUNSON</u> Last <u>BRUNSON</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1915</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MIGRANT LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ORCHARD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARION CO., S. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GERALD BRUNSON</u>		14. MOTHER'S MAIDEN NAME <u>TINA A. OWENS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS. ELOISE BRUNSON, MULLINS, S. CAROLINA</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> DUE TO <u>AGUTE CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>3 MOS</u> <u>7 MOS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-6-1965</u> , to <u>2-4-1966</u> , that (I) (we) last saw the deceased alive on <u>2-4-1966</u> , and that death occurred at <u>10:45 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Erren A. Ramirez</u> M.D.		22b. DATE SIGNED <u>2-4-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERREN A. RAMIREZ MD</u>		22d. ADDRESS <u>1500 PENN AVE, HAGERSTOWN, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>FEB. 5, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MARION CO., S. CAROLINA</u>	
24. FUNERAL DIRECTOR <u>Charles H. Koenig</u>		25a. REC'D BY REGISTRAR <u>FEB 10 1966</u>	
ADDRESS <u>HAGERSTOWN, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>50 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>917 GUILFORD AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>NETTIE</b> Middle <b>BLANCHE</b> Last <b>BUTLER</b>						4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>5</b> Year <b>19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/20/1880</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>CHARLES ALFRED PRINTZ</b>						14. MOTHER'S MAIDEN NAME <b>SARAH JANE JENKINS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. BEULAH SNYDER HAGERSTOWN MD.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis</b> <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Heart Disease</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/3</b> , 19 <b>66</b> to <b>2/5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> , 19 <b>66</b> , and that death occurred at <b>12:19</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Donald E. Martin</b>						22b. DATE SIGNED <b>2-7-66</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <b>Donald E. Martin M.D.</b>	
22d. ADDRESS <b>418 North Potomac St. Hagerstown, Md.</b>											
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>2/7/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEST HAVEN CEM.</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>			
24. FUNERAL DIRECTOR <b>W. J. Kerneant, Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. W. Jones</b>			

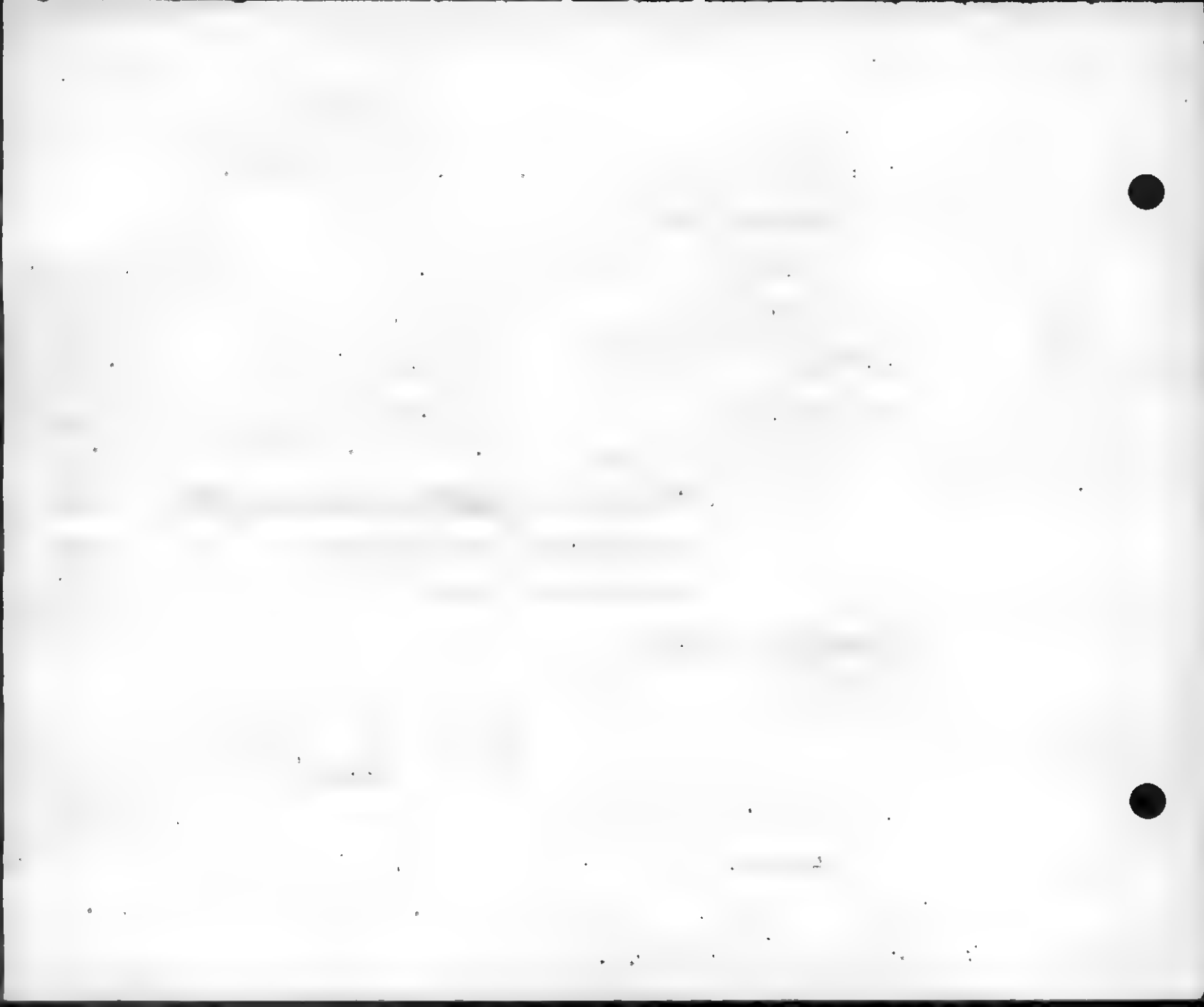




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN ID <b>40 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1074 MARSHALL ST.</b> d. STREET ADDRESS <b>HAGERSTOWN</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>SARAH MAYBELLE CARBAUGH</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>13</b> Year <b>1966</b>			5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>WHITE</b>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			9. AGE (in years last birthday) <b>68 yrs.</b> IF UNDER 1 YEAR: Months <b>13</b> Days <b>19</b> Hours <b>66</b> Min.		
13. FATHER'S NAME <b>ELMER WALLACE</b>						14. MOTHER'S MAIDEN NAME <b>SARAH MILLER</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT <b>MR. HARRY W. CARBAUGH</b>			Address <b>HAGERSTOWN MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute and subseptal</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>atherosclerosis, general</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>unk.</b> <b>unk.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>10 Feb 1966</b> to <b>13 Feb 1966</b> , that (I) (we) last saw the deceased alive on <b>13 Feb 1966</b> , and that death occurred at <b>10:20 PM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>Clovis M. Snyder, M.D.</b>						22b. DATE SIGNED <b>14 Feb-66</b>			22c. PHYSICIAN'S NAME (Type) <b>CLOVIS M. SNYDER, M.D.</b>			22d. ADDRESS <b>106 N. POTOMAC ST HAGERSTOWN, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (city, town or county) (State)					
<b>BURIAL</b>			<b>2/16/66</b>			<b>REST HAVEN CEM.</b>			<b>HAGERSTOWN MD.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>W. J. Norment, Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
						<b>FEB 18 1966</b>			<b>W. J. Norment</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

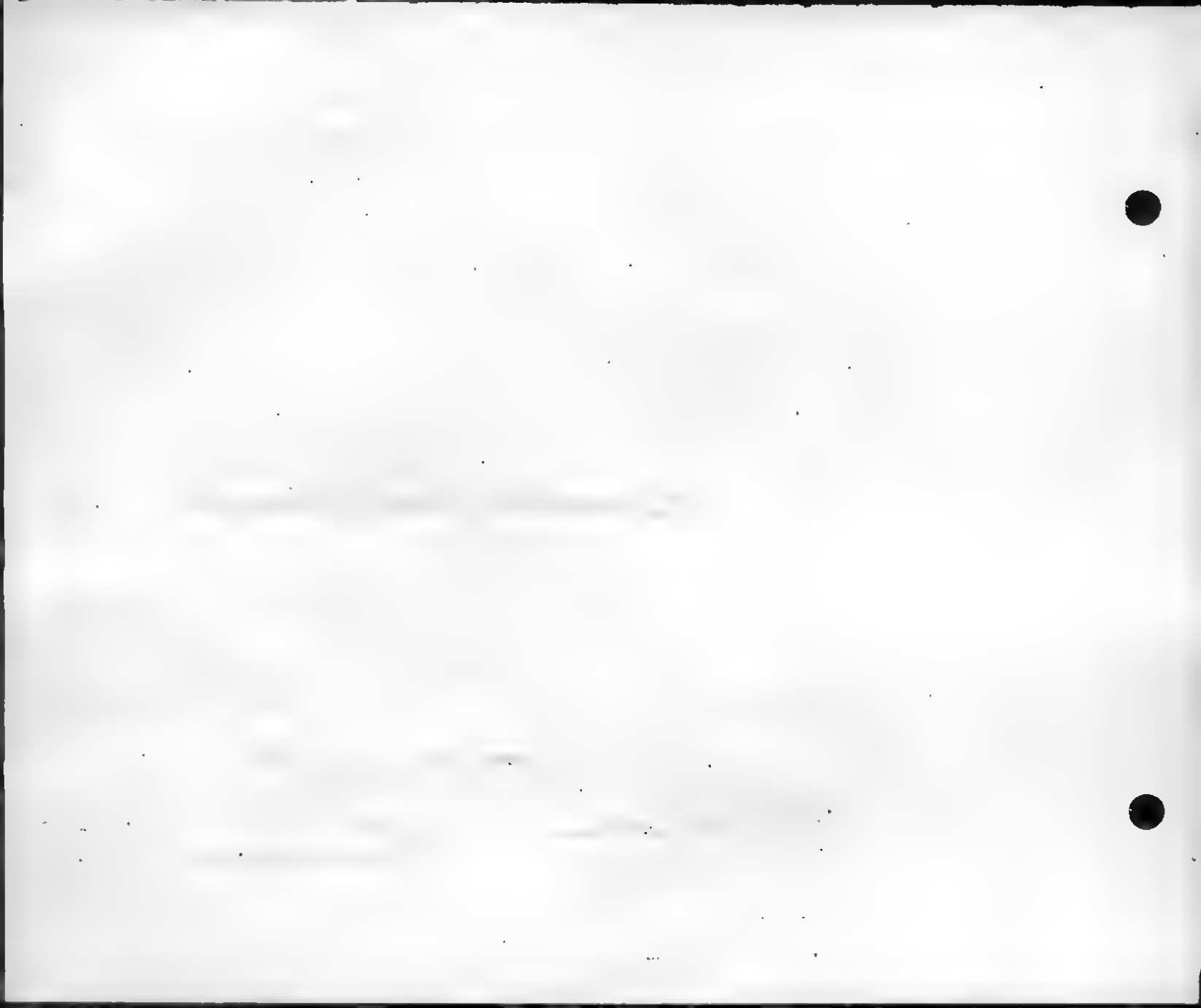
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

C2503

02882

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b 1 Yr			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reeder Nursing Home				e. STREET ADDRESS 1378 Salem Ave			
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELIZABETH Last CLARK				4. DATE OF DEATH Month Feby Day 8 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feby 14 1872	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Downsville Wash Co Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George W. Lewis				14. MOTHER'S MAIDEN NAME Elizabeth Null			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph Harsh 1378 Salem Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interventricular Heart Disease</u> 4 m. a. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1966, to Feb 8, 1966, that (I) (we) last saw the deceased alive on Feb 6, 1966, and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE G W Keenan				22b. DATE SIGNED 2/10/66			
22c. PHYSICIAN'S NAME (Type) G W Keenan				22d. ADDRESS Boonsboro, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-66		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION (City, town or county) (State) Williamsport Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Corbin Funeral Home Inc				25a. REC'D BY REGISTRAR FEB 11 1966			
				25b. REGISTRAR'S SIGNATURE Judge			






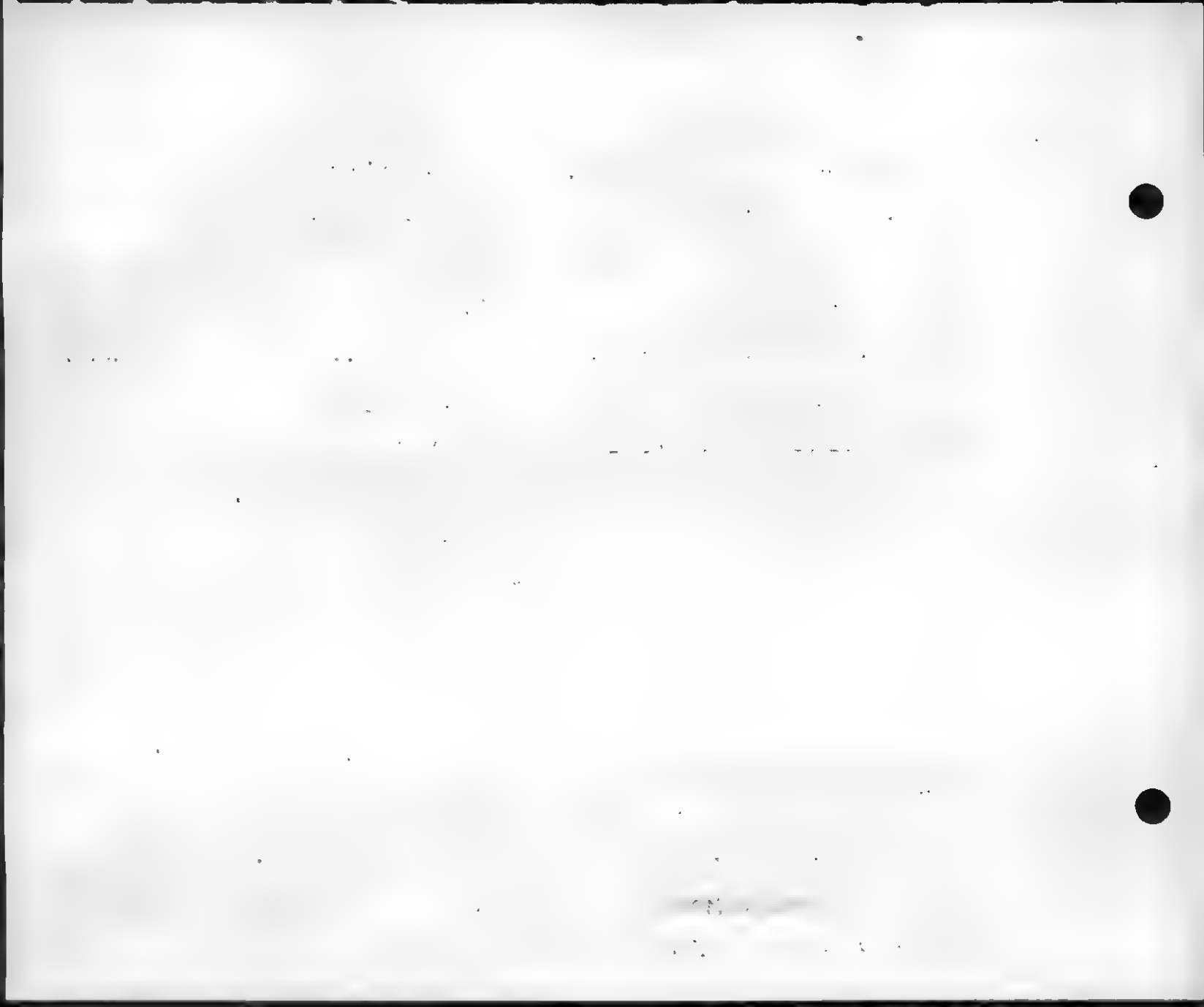
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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>27 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>338 E. FRANKLIN STREET</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>338 E. FRANKLIN STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>NORA</b>			First <b>LEVINA</b>		Middle <b>CORRIGAN</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>22</b> Year <b>1966</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 1, 1887</b>		9. AGE (In years last birthday) <b>79</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED DANCE INSTR.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DANCE SCHOOL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PASSAIC CO., N. JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>PATRICK DUFFY</b>					14. MOTHER'S MAIDEN NAME <b>JULIA KIERNAN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>215-20-9332</b>		17. INFORMANT <b>MRS. JUDY VAUGHN</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure &amp; Pulmonary Edema</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> (c) <b>Atherosclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3 MAY</b> , 19 <b>63</b> , to <b>22 FEB</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5 FEB.</b> , 19 <b>66</b> , and that death occurred at <b>6:45</b> AM, from the causes and on the date stated above.										
22a. SIGNATURE 					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM N. FENDER</b>					22d. ADDRESS <b>218 N. POTOMAC ST. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>FEB. 24, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>			
24. FUNERAL DIRECTOR 					ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>		25b. REGISTRAR'S SIGNATURE 	





TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

32505

02584

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>County Hospital</u>		d. STREET ADDRESS <u>112 Clarkson Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Edson</u> Middle <u>D.</u> Last <u>Moody</u>		4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1918</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>48</u> yrs. IF FUNER 1 YEAR <u>24</u> HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		
11. BIRTHPLACE (County & State, or foreign country) <u>Halifax Co. Virginia</u>		12. COUNTRY OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robert Adams</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>307-16-0003</u>			
17. INFORMANT <u>112 Clarkson Ave.</u> Address <u>Hagerstown, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>170X</u> DUE TO (b) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetic mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>6 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/6/25</u> , 19 <u>64</u> , to <u>2/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>66</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Edson D. Moody</u>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Edson D. Moody M.D.</u>		22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 2-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Waverly Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Williamstown, Md.</u>		
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 3 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



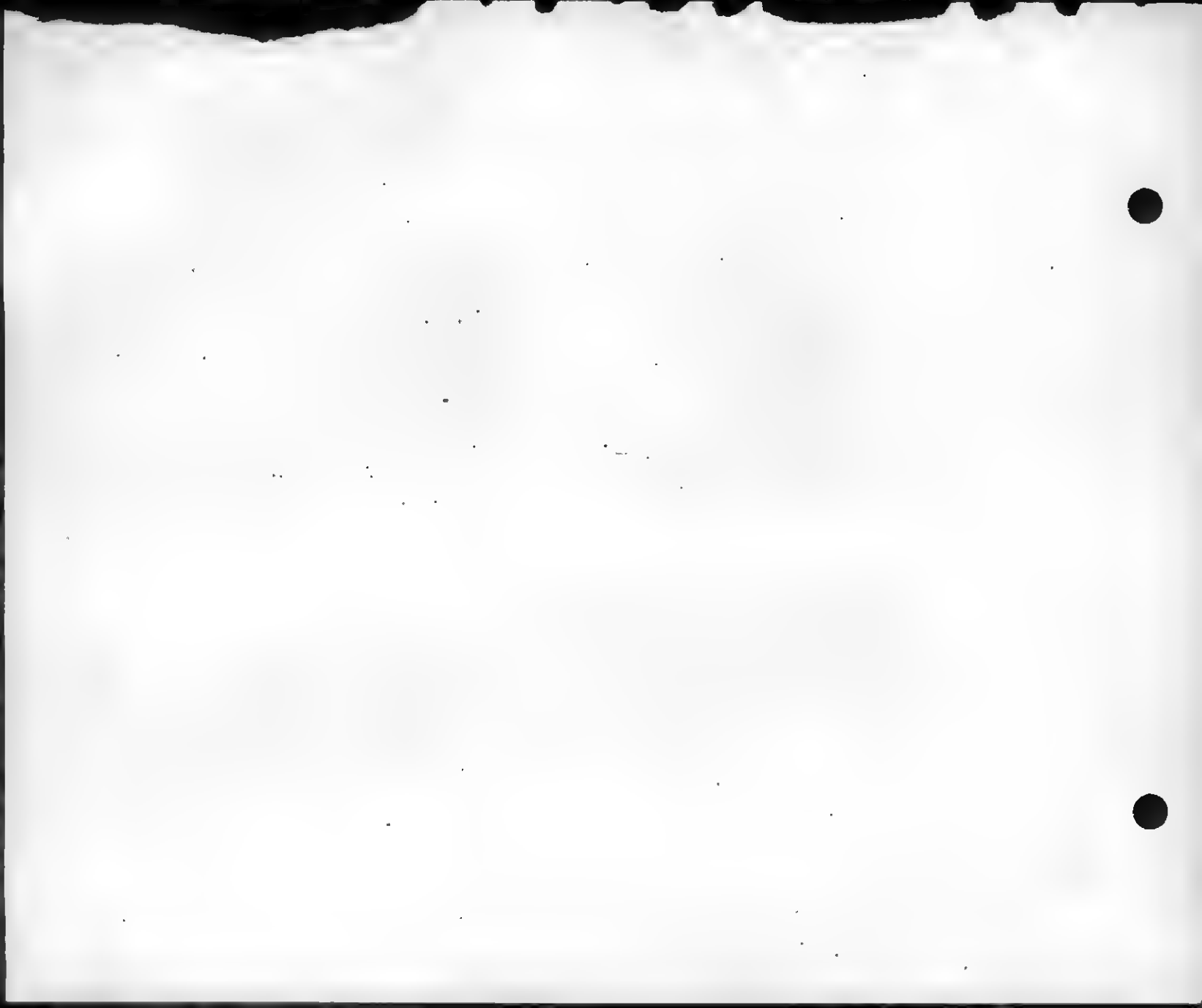
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>17 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>745 Spruce St</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>745 Spruce St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>FRANCES CATHERINE CURRY</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>Feby 6 1966</u> Month Day Year	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 24 1882</u> <b>9. AGE</b> (in years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Linden Warren Co Va.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John Sealock</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>No Record</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>214-09-7740</u> <b>17. INFORMANT</b> <u>Mrs Elsie Kump</u> Address <u>745 Spruce St Hagerstown Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 1/2</u> Years	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Apr 1965</u> , to <u>6 Feb. 1966</u> , that (I) (we) last saw the deceased alive on <u>3 Feb. 1966</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>[Signature]</u>		<b>22b. DATE SIGNED</b> <u>2/7/66</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
<b>22c. PHYSICIAN'S NAME (Type)</b>		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-8-66</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Hagerstown Wash Co Md.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Andrew K. Coffman Funeral Home Inc</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 11 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

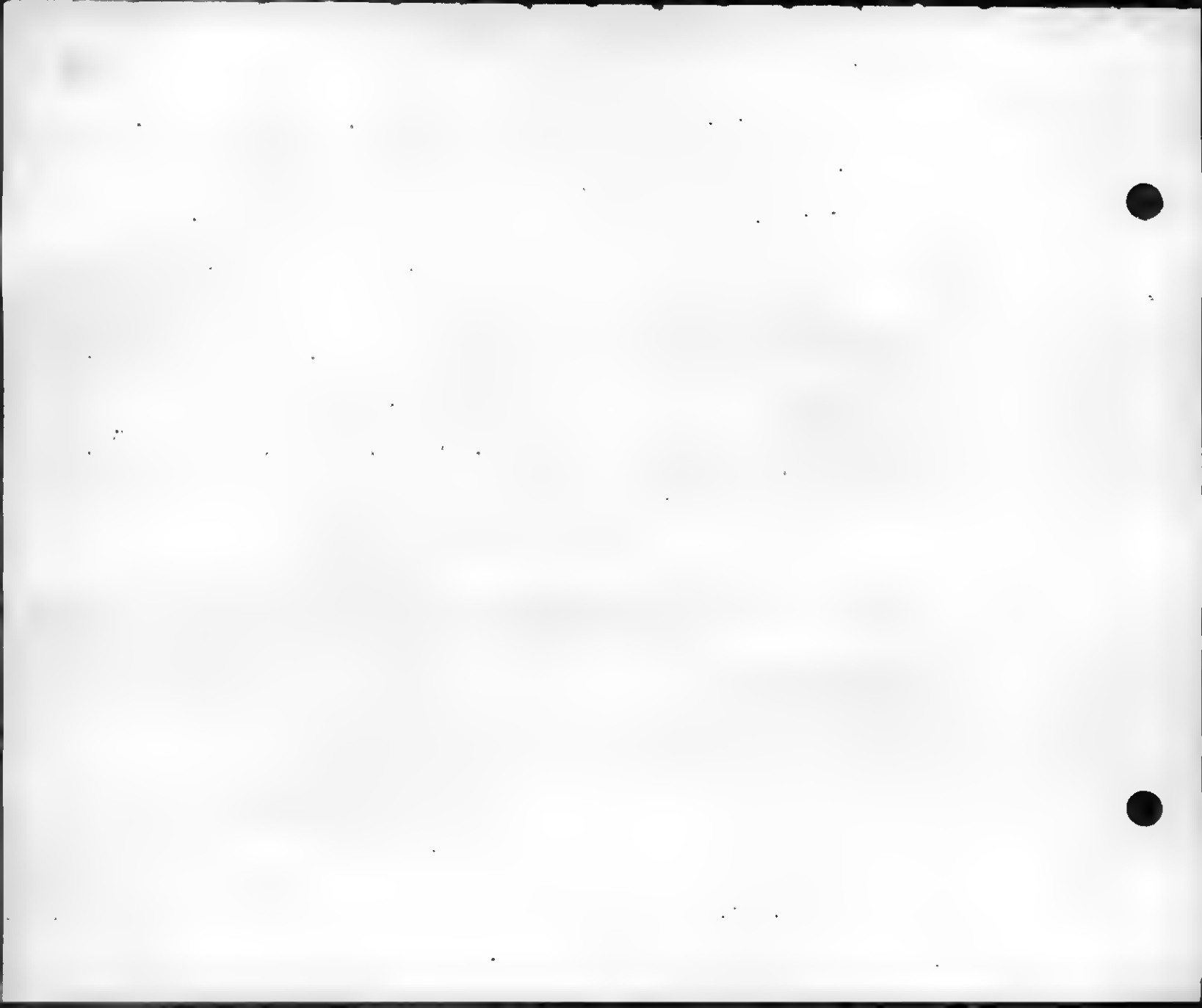
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waynesboro Pa.</u>	
c. LENGTH OF STAY IN ID <u>1 Day</u>		d. STREET ADDRESS <u>23 Barnett Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lulu Corbett Decker</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/1877</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Peter Corbett</u>	
14. MOTHER'S MAIDEN NAME <u>Christina Waugaman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Cyrus M. Corbett, Waynesboro Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic Heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10, 1966</u> to <u>Feb 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 11, 1966</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles C. Spencer</u>		22b. DATE SIGNED <u>2-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles C. Spencer</u>		22d. ADDRESS <u>143 S. Prospect St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Burns Hill</u>	23d. LOCATION (City, town or county) (State) <u>Waynesboro, Franklin Co., Pa.</u>
24. FUNERAL DIRECTOR <u>Walter J. Grove</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

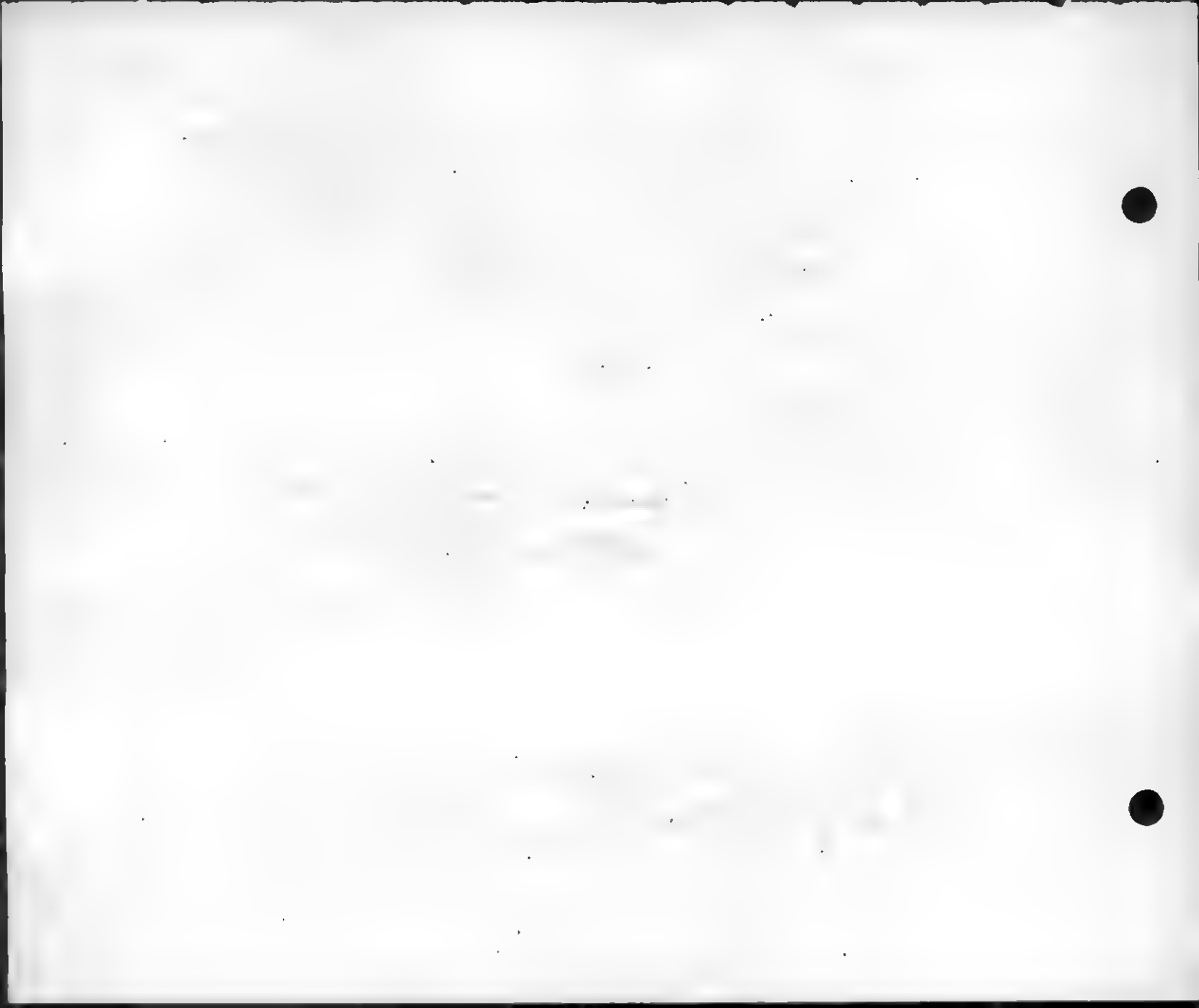


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport R. 1</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport R. # 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dellinger Road</b>		d. STREET ADDRESS <b>Dellinger Road</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>SUSAN</b> Last <b>DELLINGER</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 29 1882</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Downsville Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Rhodes</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Forthman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lewis H. Dellinger Williamsport</b>		Address <b>R. # 1 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage due to</b> DUE TO (b) <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 31</b> , 1966, to <b>Feb 2</b> , 1966, that (I) (we) last saw the deceased alive on <b>Feb 1</b> , 1966, and that death occurred at <b>4 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Sidney Hovener</b>		22b. DATE SIGNED <b>2-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SIDNEY HOVENER, M.D.</b>		22d. ADDRESS <b>FUMESKOR MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bakersville Wash Co. Md</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>Feb 3 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





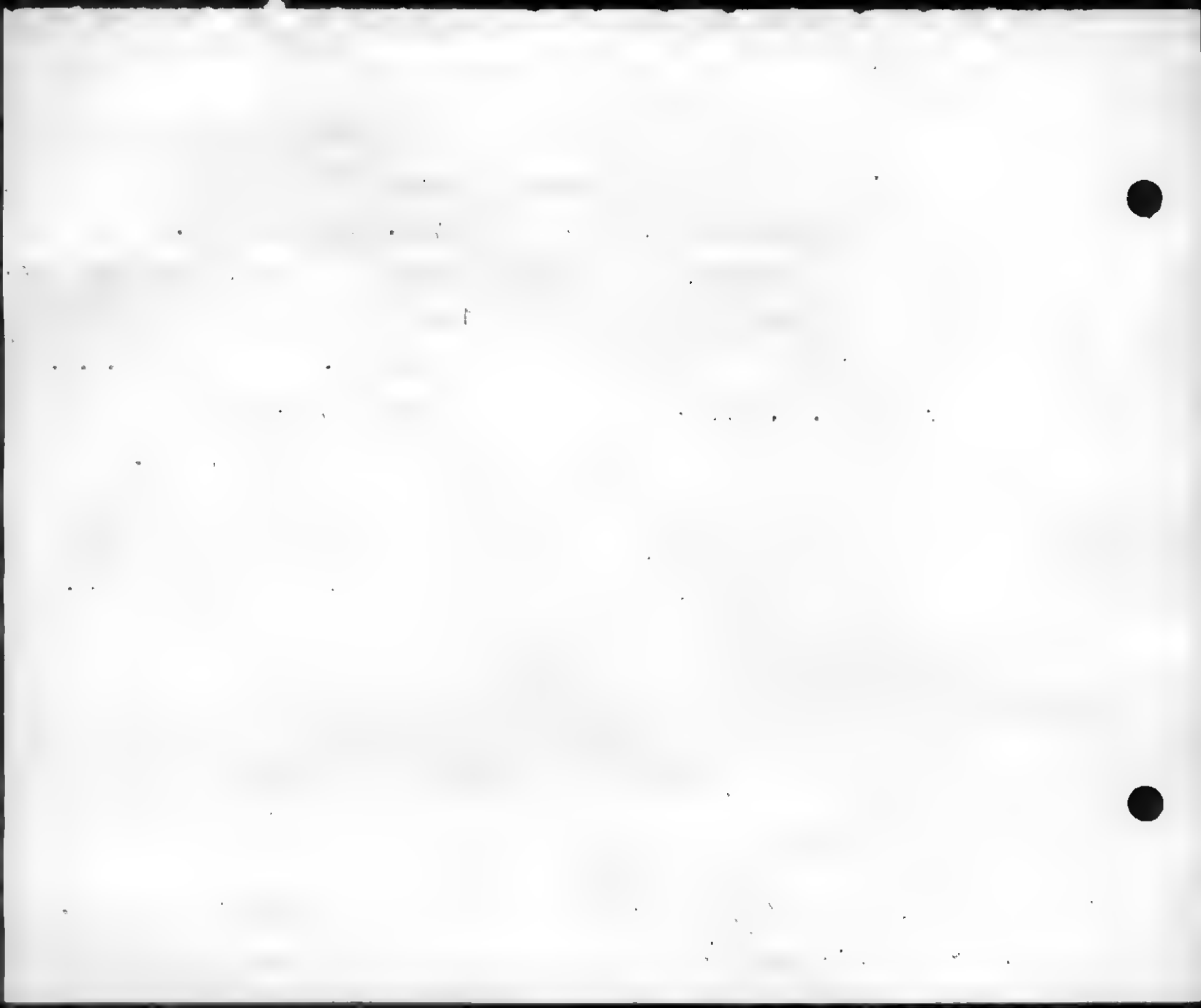
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M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN ID <b>8 MONTHS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		d. STREET ADDRESS <b>447 W. WASHINGTON ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JEANETTE ESTELLA EDMOND</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 19 19 66</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/21/1921</b>		9. AGE (In years last birthday) <b>44 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH H. F. MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>VIRGIE B. ALEXANDER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>NADENE GRAIL</b>		Address <b>BALTIMORE MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio vas. C. 1/14/66</b> 55.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Circ. hosis Liver</b> DUE TO (c) <b>Hepatocellular Dis. Liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>10</b> <b>15</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>447 W. WASHINGTON ST. HAGERSTOWN MD.</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>2/1/66</b> , 19 <b>66</b> , to <b>2/14/66</b> , that (I) (we) last saw the deceased alive on <b>2/14/66</b> , 19 <b>66</b> , and that death occurred at <b>2:14</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Louis G. Croft</b>		22b. DATE SIGNED <b>2-24-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Louis G. Croft</b>		22d. ADDRESS <b>500 North Ave HAGERSTOWN MD.</b>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/22/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>		25a. REC'D BY REGISTRAR <b>W. J. Norman, Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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02510

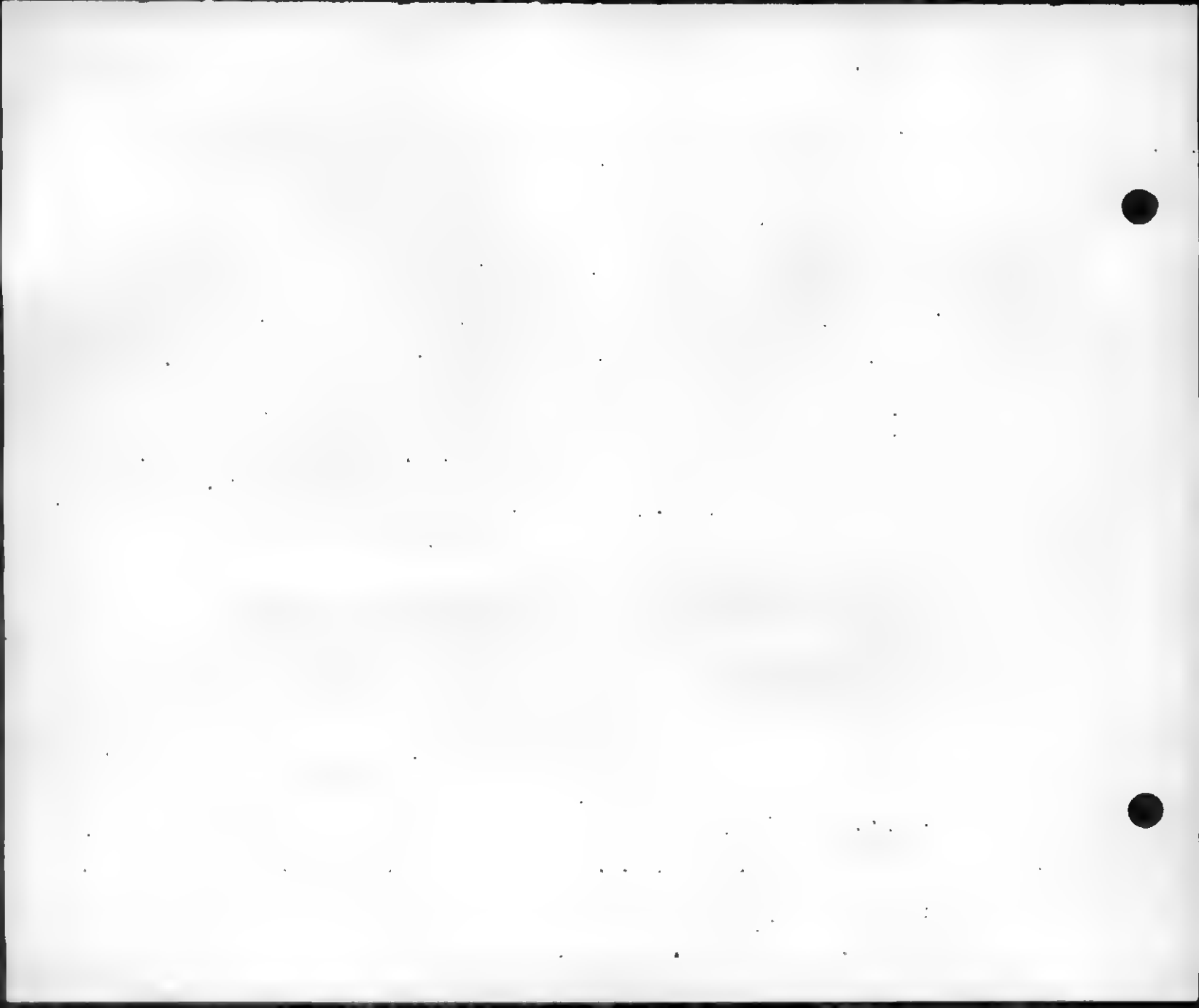
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02889

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN ID 3 Yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1028 Potomac Ave								d. STREET ADDRESS 1028 Potomac Ave			
3. NAME OF DECEASED (Type or print) HANNA LYON EINBINDER				4. DATE OF DEATH Feby 8 1966				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 16 1933		9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Loses Lyon				14. MOTHER'S MAIDEN NAME Rosa Machinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. -----				17. INFORMANT Irving L. Einbinder 42 No Jonathan			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Leiomycosarcoma of Stomach</i> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that (I) (this hospital) attended the deceased from 9-9-58, 19, to 2-8, 1966, that (I) last saw the deceased alive on 2-8, 1966, and that death occurred at 11:49 AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>Dalton M. Velty</i>								22b. DATE SIGNED 2-8-66			
22c. PHYSICIAN'S NAME (Type) Dalton M. Velty, M.D.								22d. ADDRESS 993 Potomac Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-9-66				23c. NAME OF CEMETERY OR CREMATORY Piney Abraham Cemetery			
23d. LOCATION (City, town or county) Hagerstown				(State) Md.				23e. LOCATION (City, town or county) Halfway Wash Co Md.			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc								25. REGISTRAR'S SIGNATURE J. Charles Judge			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02011

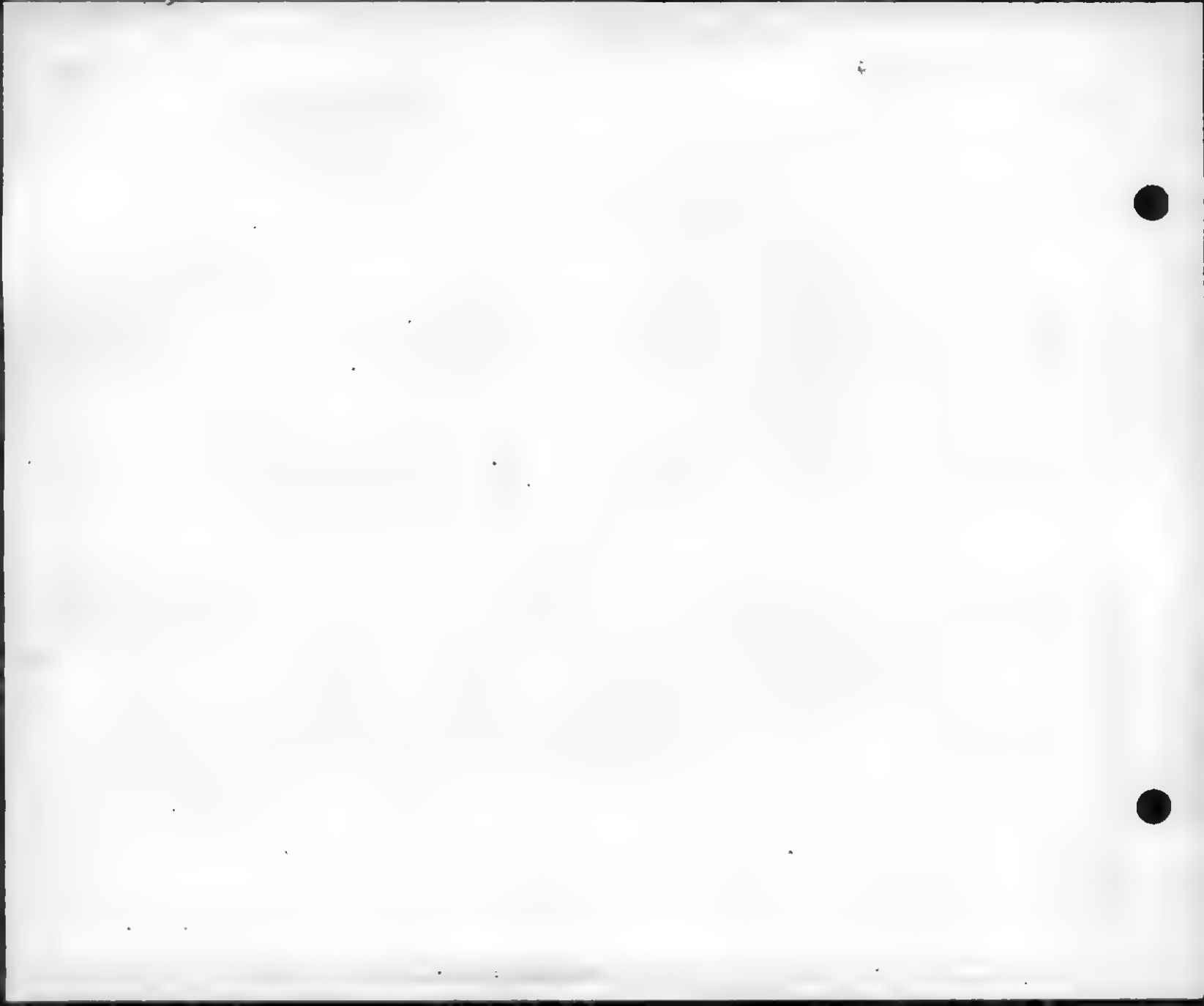
## CERTIFICATE OF DEATH

02890

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>68 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Friendship Manor Nursing Home</b>				d. STREET ADDRESS <b>120 Bower Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>LENA</b> Last <b>EVERHART</b>				4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1884</b>	9. AGE (n years last birthday) <b>81</b> yrs	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		11. IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Page, Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Page, Co. Va.</b>	
13. FATHER'S NAME <b>George Louderbach</b>				14. MOTHER'S MAIDEN NAME <b>Mary unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>---</b>		17. INFORMANT Address <b>Mrs. Edward Pearman Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Thrombosis</b> (c) <b>Chronic Sclerosis</b> <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 20, 1966</b> , to <b>Feb 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 22, 1966</b> , and that death occurred at <b>3:00 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>J. H. Beaghtley M.D.</b>		22b. PHYSICIAN'S NAME (Type) <b>J. H. Beaghtley</b>		22c. ADDRESS <b>Hagerstown, Md.</b>		22d. DATE SIGNED <b>Feb. 24/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-24-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son</b>				25a. REC'D BY REGISTRAR <b>MAR 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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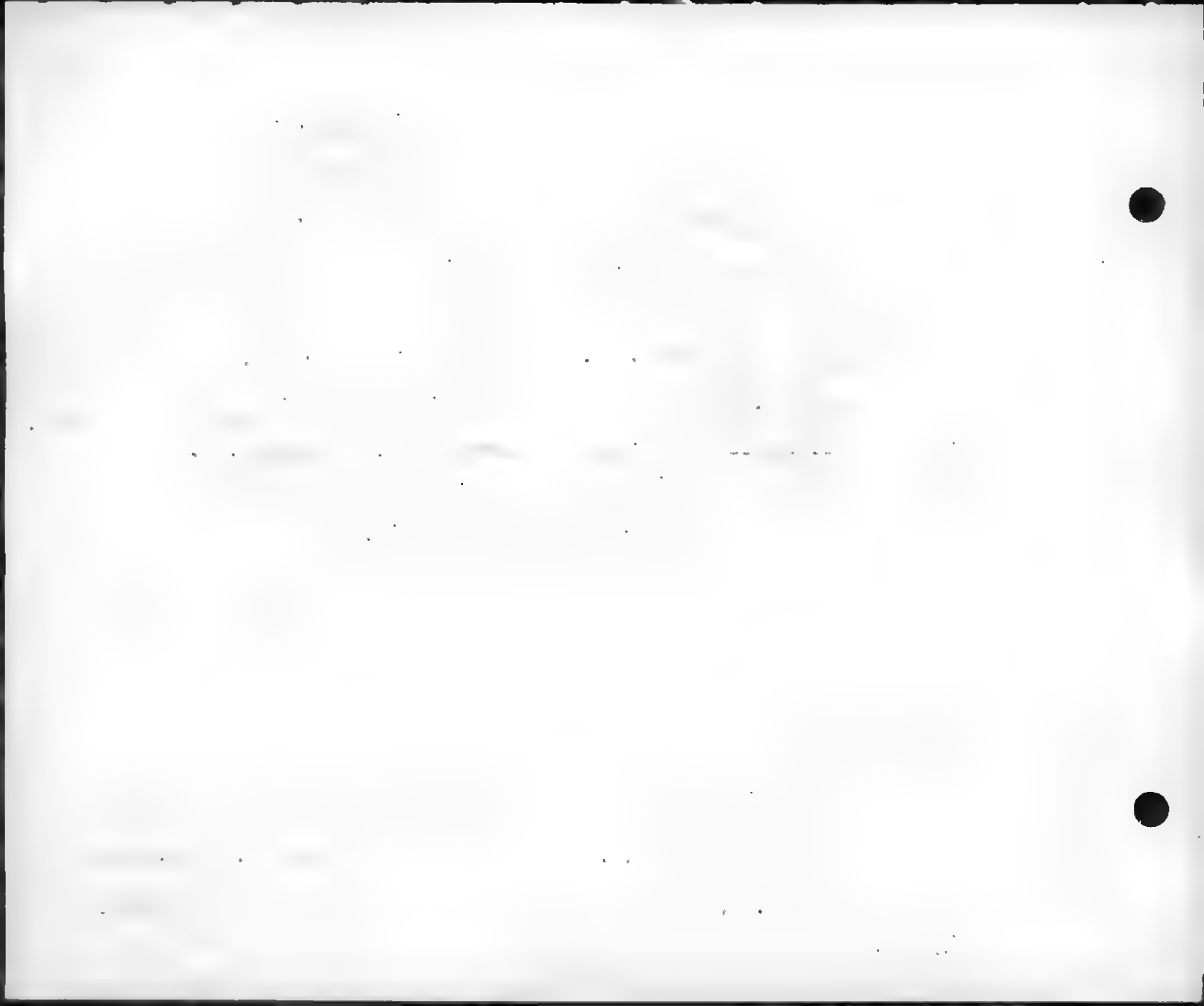


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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
028912 CERTIFICATE OF DEATH 02891									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>FRANKLIN</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN 1b <b>UNKNOWN</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHAMBERSBURG</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CLEARVIEW NURSING HOME</b>					d. STREET ADDRESS <b>937 WILSON AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EUGENE</b> Last <b>FISLER</b>					4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>4</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 2, 1875</b>		9. AGE (In years last birthday) <b>90</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TIMEKEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MANUF. CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN CO. PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID B. FISLER</b>					14. MOTHER'S MAIDEN NAME <b>REBECCA GROVE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>JAMES FISLER, 50 CONNER AVE.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO (b) <i>arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic arteriosclerosis</i>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>5/10</b> , 19 <b>65</b> , to <b>Feb 4</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Jan 12</b> , 19 <b>66</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Edson B. Moody</i>					22b. DATE SIGNED <b>2/6/1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>EDSON B. MOODY M.D.</b>					22d. ADDRESS <b>145 S. PROSPECT ST. HAGERSTOWN</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>FEB. 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NORLAND CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>CHAMBERSBURG PENNA.</b>			
24. FUNERAL DIRECTOR <i>Charles Judge</i> <b>HAGERSTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>FEB 11 1966</b>				
					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film G374 2/20/66

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02913

CERTIFICATE OF DEATH

12892

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home</u>		d. STREET ADDRESS <u>132 N. Locust St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Hossie</u> Middle <u>L</u> Last <u>Flory</u>		4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alex McAlvey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Singer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Pauline Wiederhold</u>		Address <u>Williamsport, Md.</u> <u>18 N. Potomac St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>nephritis &amp; nephrosclerosis</u> DUE TO <u>infectious</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO <u>arteriosclerosis</u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis C.V.D. &amp; gen. arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>H.N. Weeks</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>H.N. Weeks M.D.</u>		22d. ADDRESS <u>580 Northern Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Rest Haven Funeral Chapel Hagerstown, Md.		DATE <u>FEB 14 1966</u>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

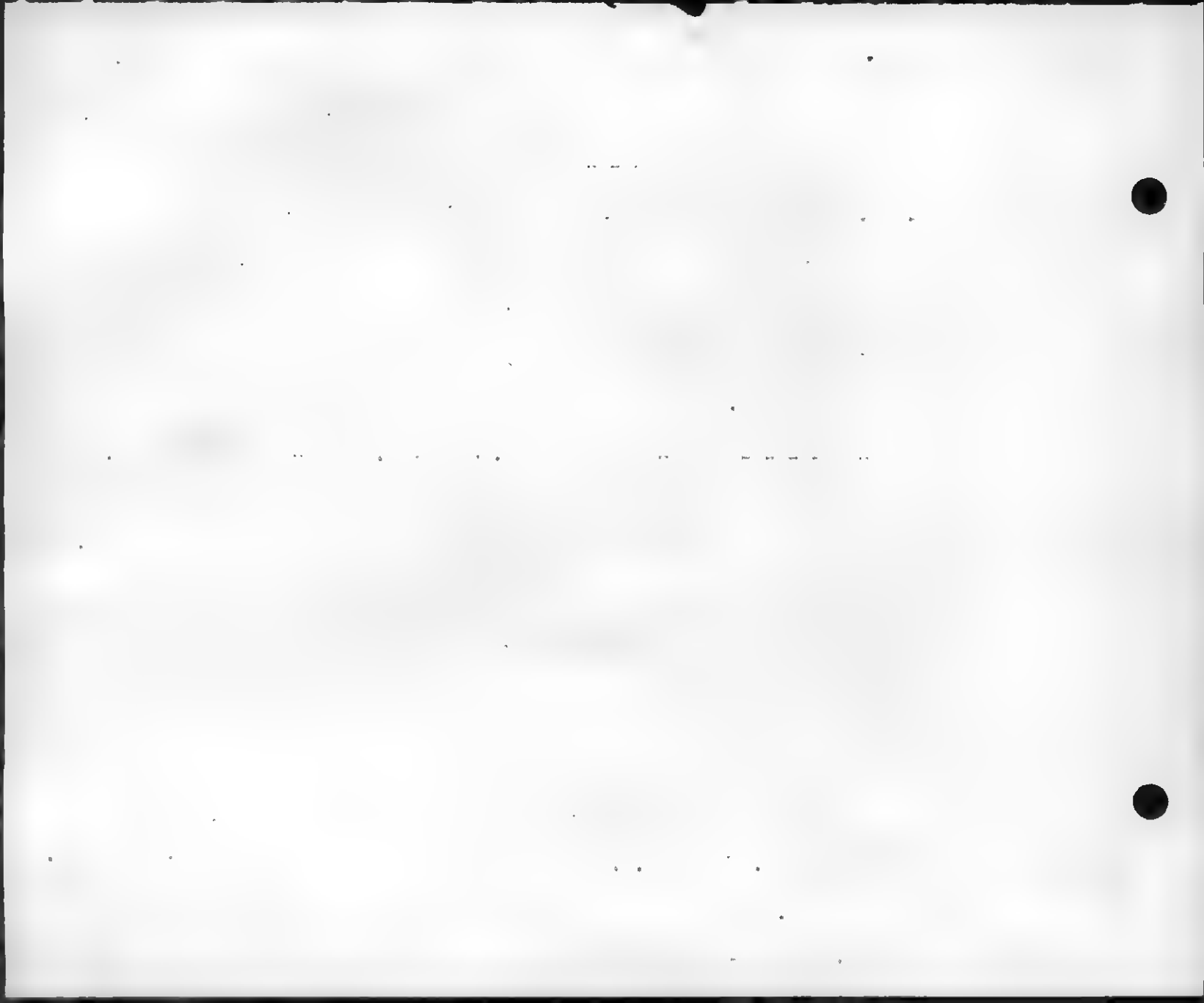
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02293

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>----</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>230 SUMMIT AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH MARSHALL FORD</b>		4. DATE OF DEATH <b>FEBRUARY 18, 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 7, 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PAINTING CONTRACT.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM M. FORD</b>		14. MOTHER'S MAIDEN NAME <b>LAURA BERRY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-24-1770</b>	
17. INFORMANT <b>HAGERSTOWN, MARYLAND</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> 1463X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <b>Phlebitis of the leg</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease.</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		20. SEVERITY OF DEATH <b>Sev. mos.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		M.D. <b>2-19-66</b> 22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>HOWARD N. WEEKS, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>580 NORTHERN AVE. HAGERSTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 22, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER - HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 24 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

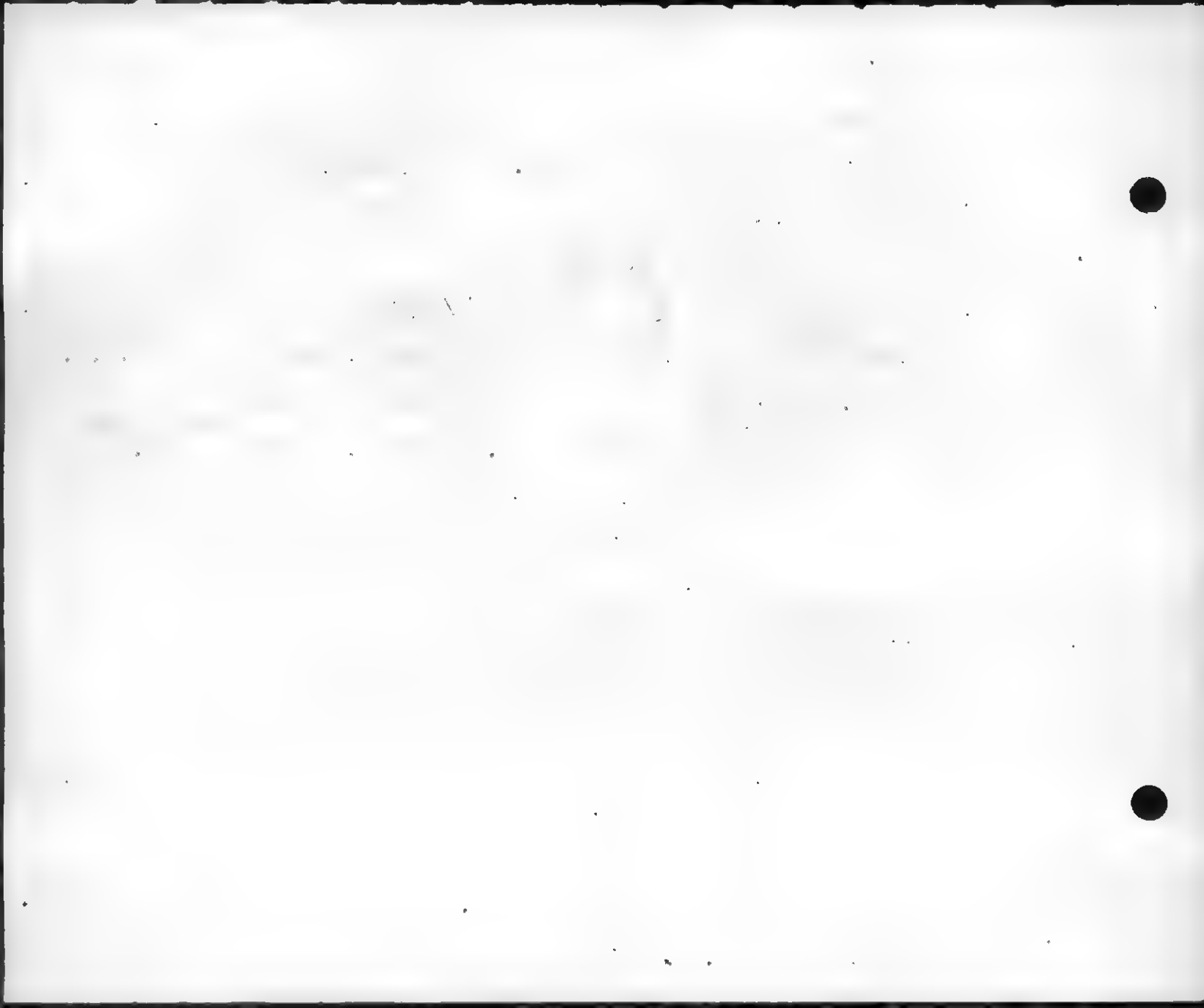


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
022913 CERTIFICATE OF DEATH 022994

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>1 YR 2 MO.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>407 SHERWOOD DRIVE</b>		d. STREET ADDRESS <b>407 SHERWOOD DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>ADAH</b> Middle <b>RACHAEL</b> Last <b>FRICK</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>12</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/28/1877</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY J. DINTINGER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH WASHBURNE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. ROBERT C. FRICK</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Myocardial infarction</b> DUE TO (c) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>4 mos</b> <b>4 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1, 1951</b> , to <b>Feb 12, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 12, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. L. Parker Jr</b>		22b. DATE SIGNED <b>2/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. L.</b>		22d. ADDRESS <b>M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/15/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DENISON CEM.</b>	23d. LOCATION (City, town or county) (State) <b>FORTY FORT PENNA.</b>
24. FUNERAL DIRECTOR <b>W. J. Harment, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 17 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>W. J. Harment</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and notify event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02916						02895					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>35 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>						d. STREET ADDRESS <u>411 Elizabeth Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Violet Belle Hammer</u>						4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 1, 1884</u>		9. AGE (in years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bald Eagle, Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin McClain</u>						14. MOTHER'S MAIDEN NAME <u>Ella A. Dunlap</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-3835</u>		17. INFORMANT Address <u>Mr. R.W. Hammer 411 Elizabeth Ave. Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 4</u> , 19 <u>63</u> , to <u>FEB 6</u> , 19 <u>66</u> , that (I) <u>two</u> last saw the deceased alive on <u>FEB 6</u> , 19 <u>66</u> , and that death occurred at <u>6:58</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Efrén Ramirez</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-7-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>EFRÉN RAMIREZ</u>						22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. C. Hart</u>						ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	

Handwritten text at the bottom of the page, possibly a signature or date.



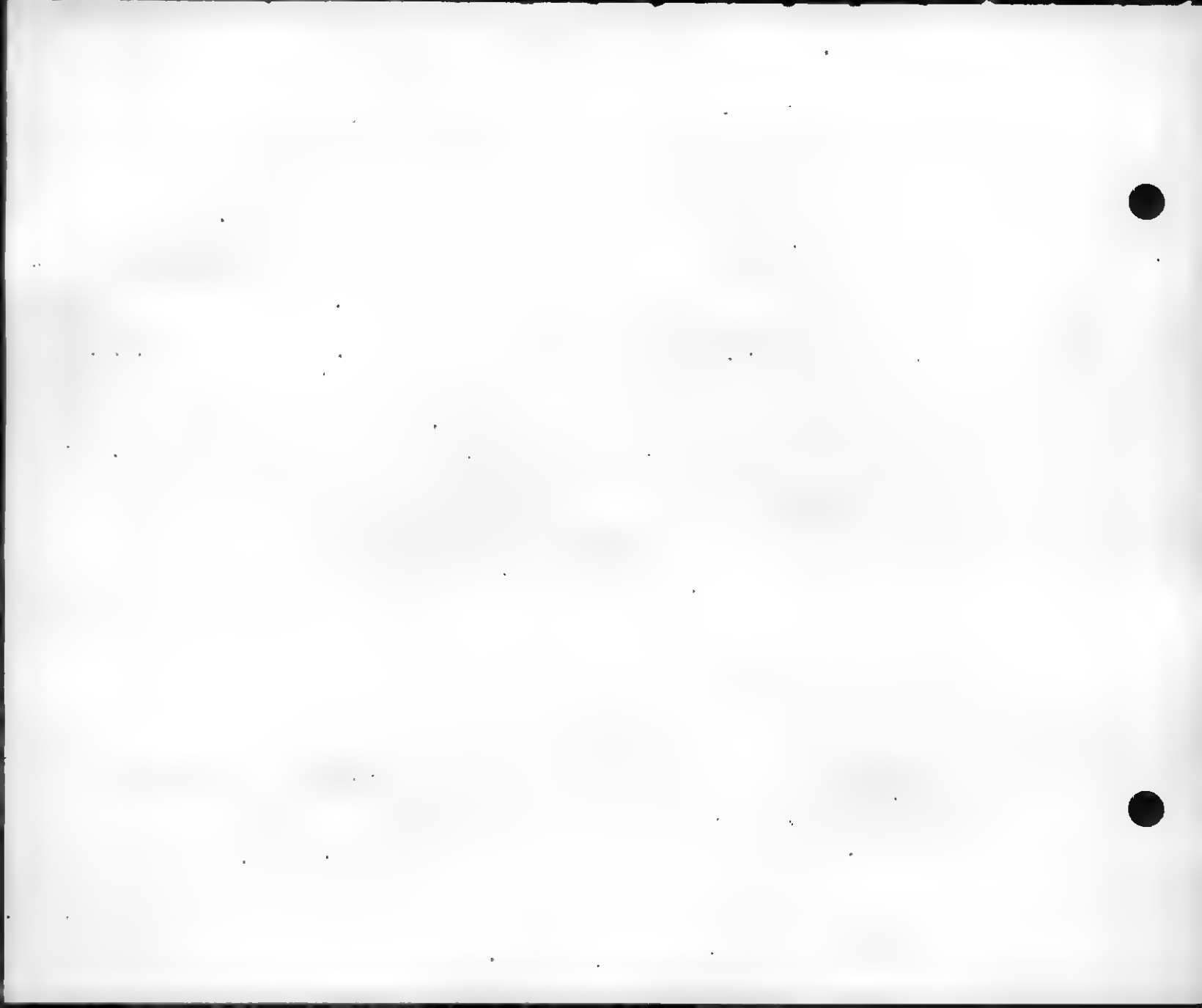
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02917 CERTIFICATE OF DEATH 02896

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 7			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 715 Fairview Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES G. HARPER				4. DATE OF DEATH Month Day Year Feb. 2 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 28, 1885	
9. AGE (In years last birthday) 80 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Landis Mach. Co.		10b. KIND OF BUSINESS OR INDUSTRY Machine Tool		11. BIRTHPLACE (County & State, or foreign country) Bangor Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Harry Harper			
14. MOTHER'S MAIDEN NAME Carrie Jamsher				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 173-03-1188		17. INFORMANT Mrs. Arch Thomas, 415 W. Sixth St., Pa.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 16058 DUE TO CARDIO-PULMONARY COLLAPSE (b) DUE TO CANCER of Right Lung (c) DUE TO PULMONARY EMPHYSEMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANTHEROSCLEROTIC HEART DISEASE ANEMIA INTERVAL BETWEEN ONSET AND DEATH 2 days UNKNOWN UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 20, 1966, to Feb 2, 1966, that (I) (we) last saw the deceased alive on Feb 2, 1966, and that death occurred at 4:50 PM, from the causes and on the date stated above.							
22a. SIGNATURE E. R. Rardizabal				22b. DATE SIGNED 2-3-66			
22c. PHYSICIAN'S NAME (Type) E. R. RARDIZABAL M.D.				22d. ADDRESS 2 North Ave Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/66		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City/town or county) (State) Waynesboro, Franklin Co., Pa.	
24. FUNERAL DIRECTOR Walter G. Greer				25a. REC'D BY REGISTRAR ECB 8 1966		25b. REGISTRAR'S SIGNATURE John Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

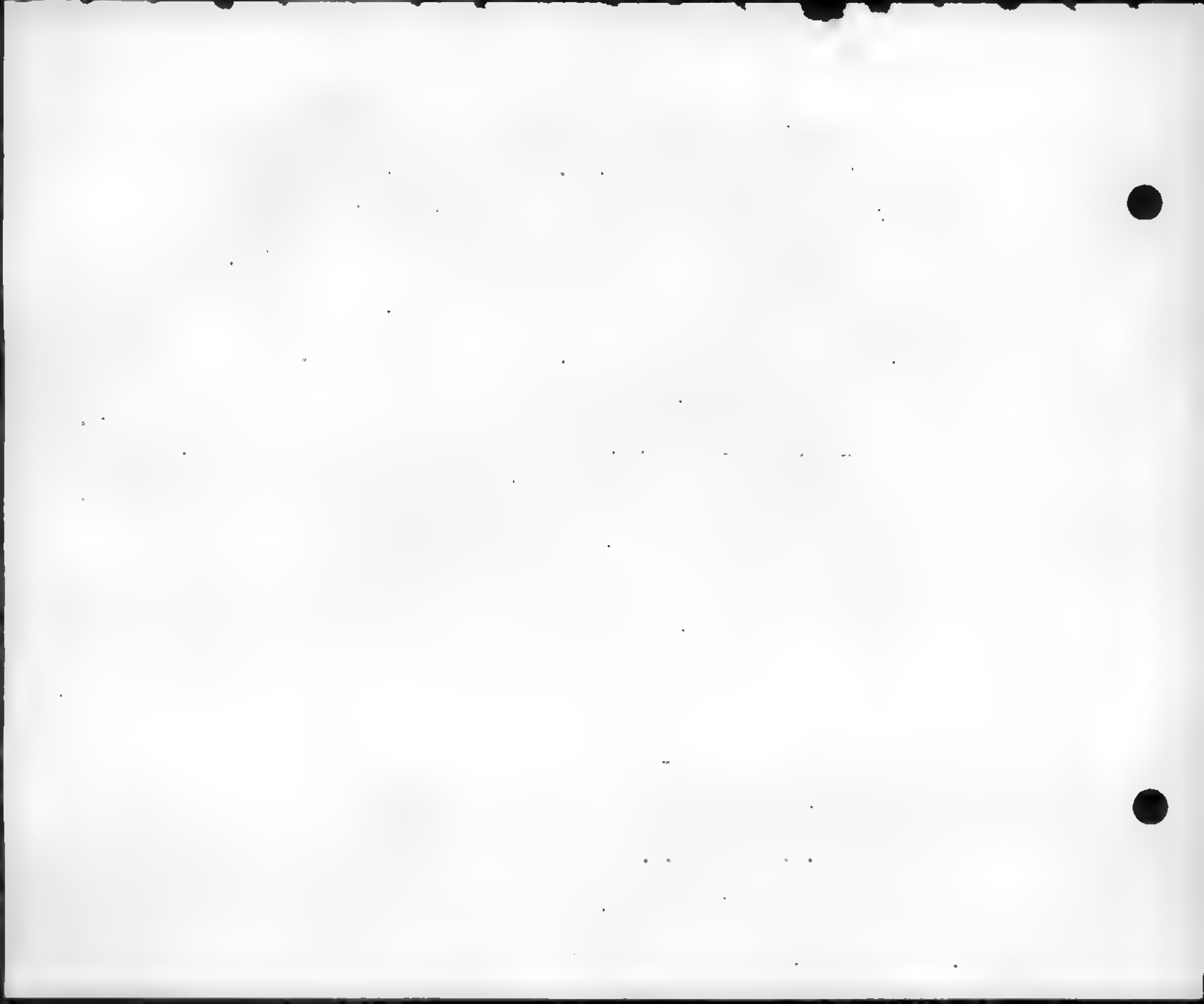
M

02918

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02907

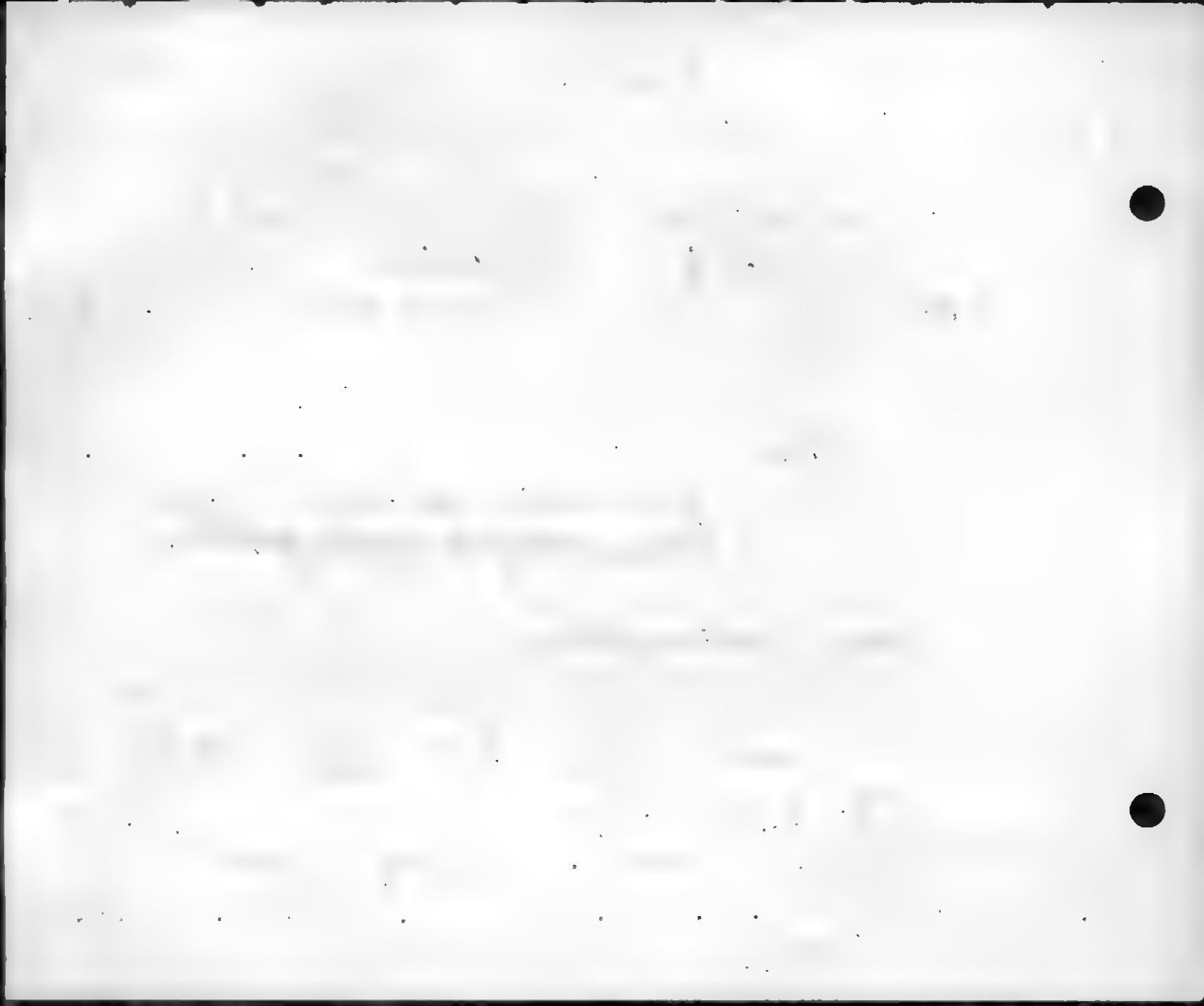
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>30 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>724 POTOMAC AVENUE</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>724 POTOMAC AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CLARA</b>		Middle <b>ELIZABETH</b>		Last <b>HARTLE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>20</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 27, 1896</b>	
9. AGE (In years last birthday) <b>69</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HAND SEWER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRESS MFG.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN L. DUTROW</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. BUSSARD</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>217-28-1188</b>		17. INFORMANT <b>JOHN A. HARTLE</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b> (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>20 Feb</b> , 19 <b>66</b> , that (I) <del>last</del> saw the deceased alive on <b>15 Feb</b> 19 <b>66</b> , and that death occurred at <b>11:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J.D. Wilson</b>		M.D. <b>J.D. WILSON M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/22/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J.D. WILSON M.D.</b>		22d. ADDRESS <b>580 NORTHERN AVE., HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEBRUARY 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Charles J. Jones</b>		ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>Charles J. Jones</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	



TO **MEDICAL OR ATTENDING PHYSICIAN**. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO **FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN ID <u>10 1/2 hr</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown 21-</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON County.</u>				d. STREET ADDRESS <u>229 Prospect St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>TWIN II PAUL</u>				4. DATE OF DEATH <u>Feb 19 1966</u>				5. AGE (In years last birthday) <u>19</u> <u>10</u> <u>30</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 18, 1966</u>		9. AGE (In years last birthday) <u>19</u> <u>10</u> <u>30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>RICHARD A. HAUVER JR</u>				14. MOTHER'S MAIDEN NAME <u>KITTY-TSCHIFFELY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Richard A. Hauver, Jr. Thurmont, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 1 lb 13 oz (Twin)</u> DUE TO (b) <u>Primary incomplete expansion of the lungs</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>—</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Low birth weight Premature labor</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>— 19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/18/66</u> , 19 <u>66</u> , to <u>2/19, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/18 1966</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>A. M. Bacon Jr</u>				22b. DATE SIGNED <u>2/20/66</u>				22c. PHYSICIAN'S NAME (Type) <u>A. M. Bacon Jr.</u>			
22d. ADDRESS <u>101 King St Hagerstown Md</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
23b. DATE THEREOF <u>Feb. 21. 66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cem</u>				23d. LOCATION (City, town or county) (State) <u>Foxville, Fredk. Co. Md</u>			
24. FUNERAL DIRECTOR <u>Raymond E. Buegel</u>				25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>				25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>			



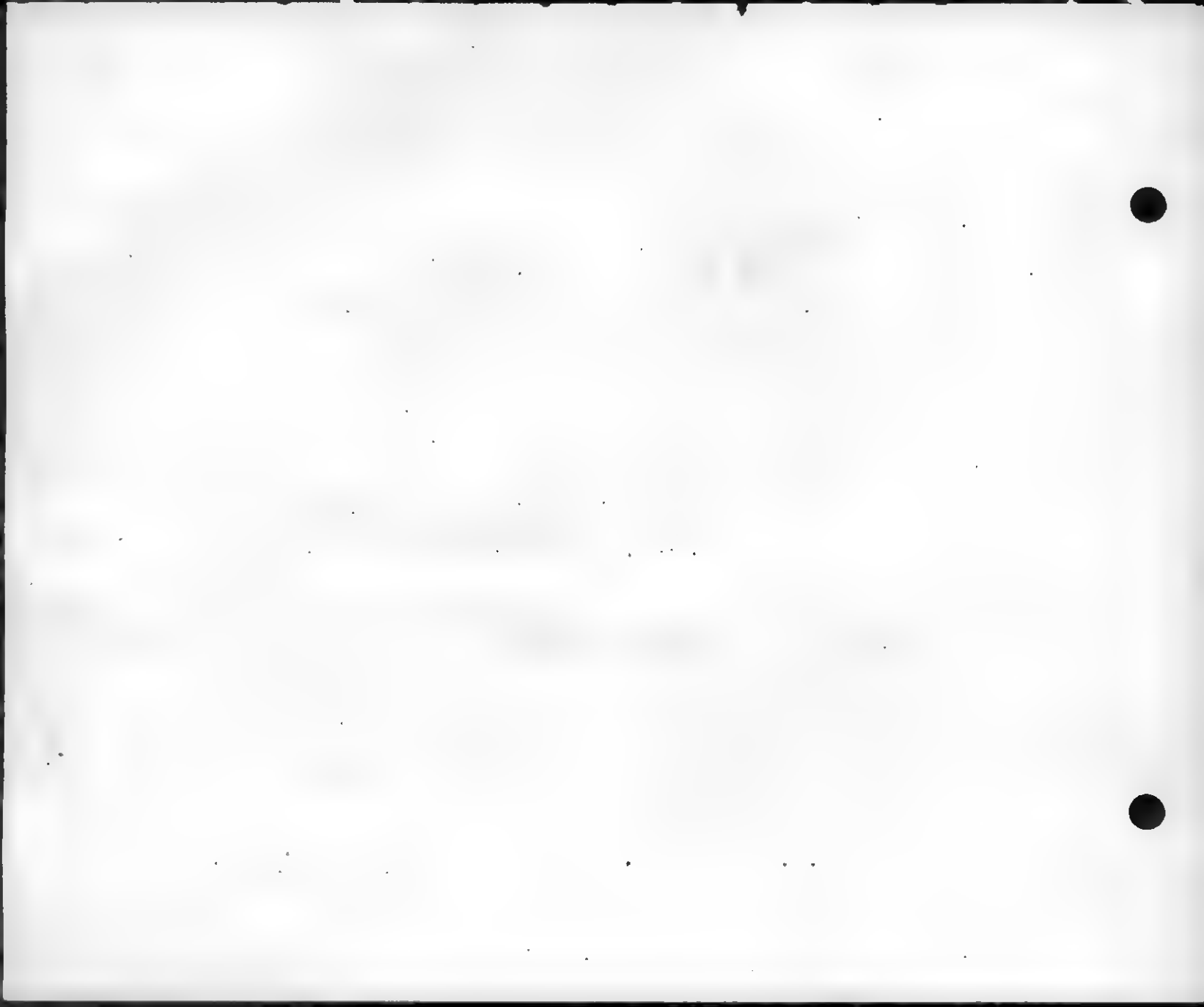
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>8 1/2 hr</u>		d. STREET ADDRESS <u>229 S. Prospect</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON County</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>TWIN PETER</u> First Middle Last	4. DATE OF DEATH <u>Feb 19 1966</u> Month Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18, 1966</u>
9. AGE (In years last birthday) <u>8</u> yrs. Months <u>0</u> Days <u>30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>RICHARD A. HAUSER JR</u>		14. MOTHER'S MAIDEN NAME <u>KITTY TSCHIFFELY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Richard A Hauser</u> Address <u>Thurmont Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emmaturity 2 lbs 3 oz (Twin)</u> DUE TO (b) <u>Premature incomplete expansion of lungs</u> DUE TO (c) <u>(Severe)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Twin - Premature labor</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/18/66</u> , 19 <u>66</u> , to <u>2/19/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/18/66</u> , 19 <u>66</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Bacon</u>		22b. DATE SIGNED <u>2/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.M. Bacon, Jr.</u>		22d. ADDRESS <u>101 King St Hagerstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Feb 21-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>mt moriah Cem</u>	23d. LOCATION (City, town or county) (State) <u>Thurmont Md</u>
24. FUNERAL DIRECTOR <u>Raymond E. Gager</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





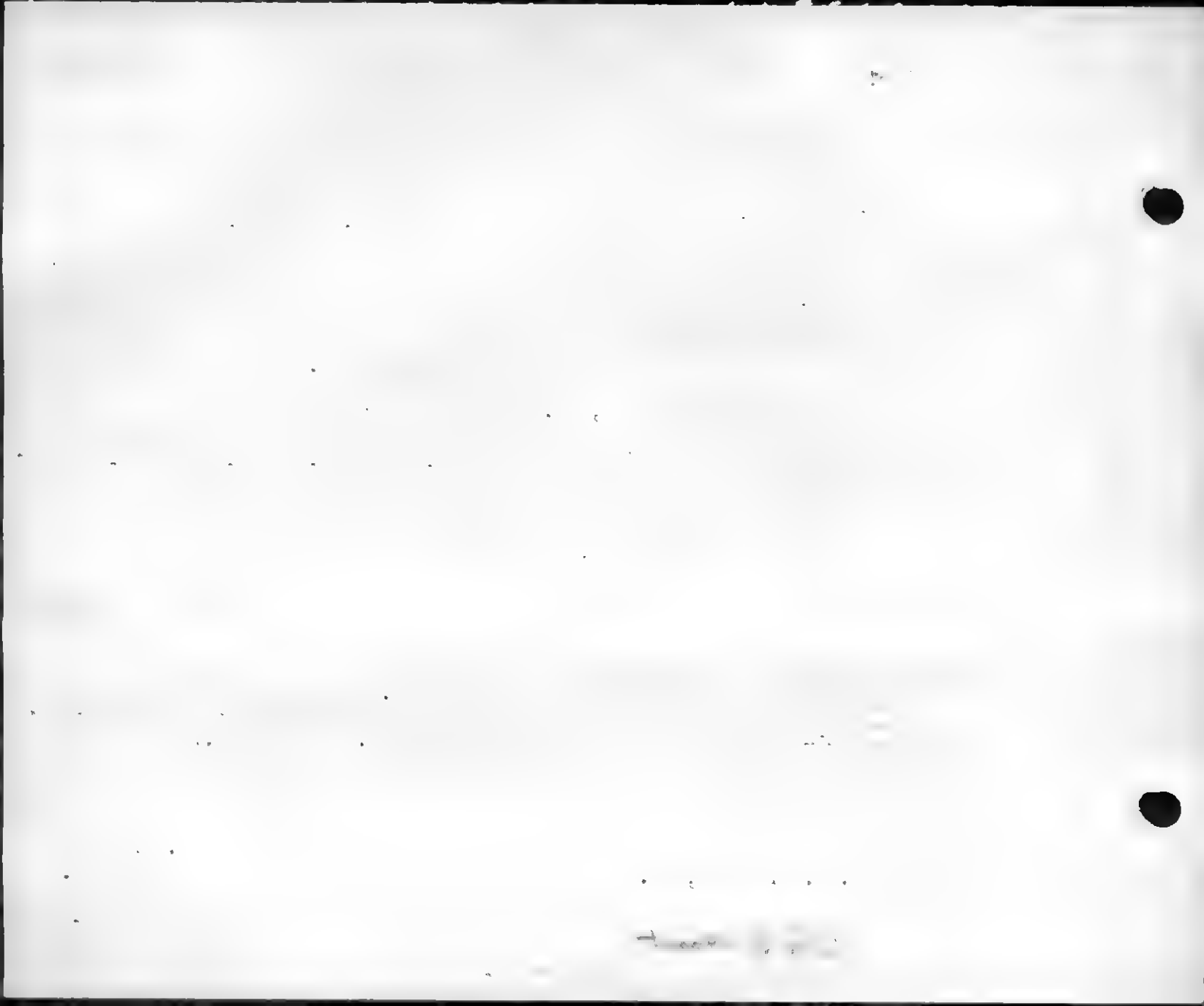
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

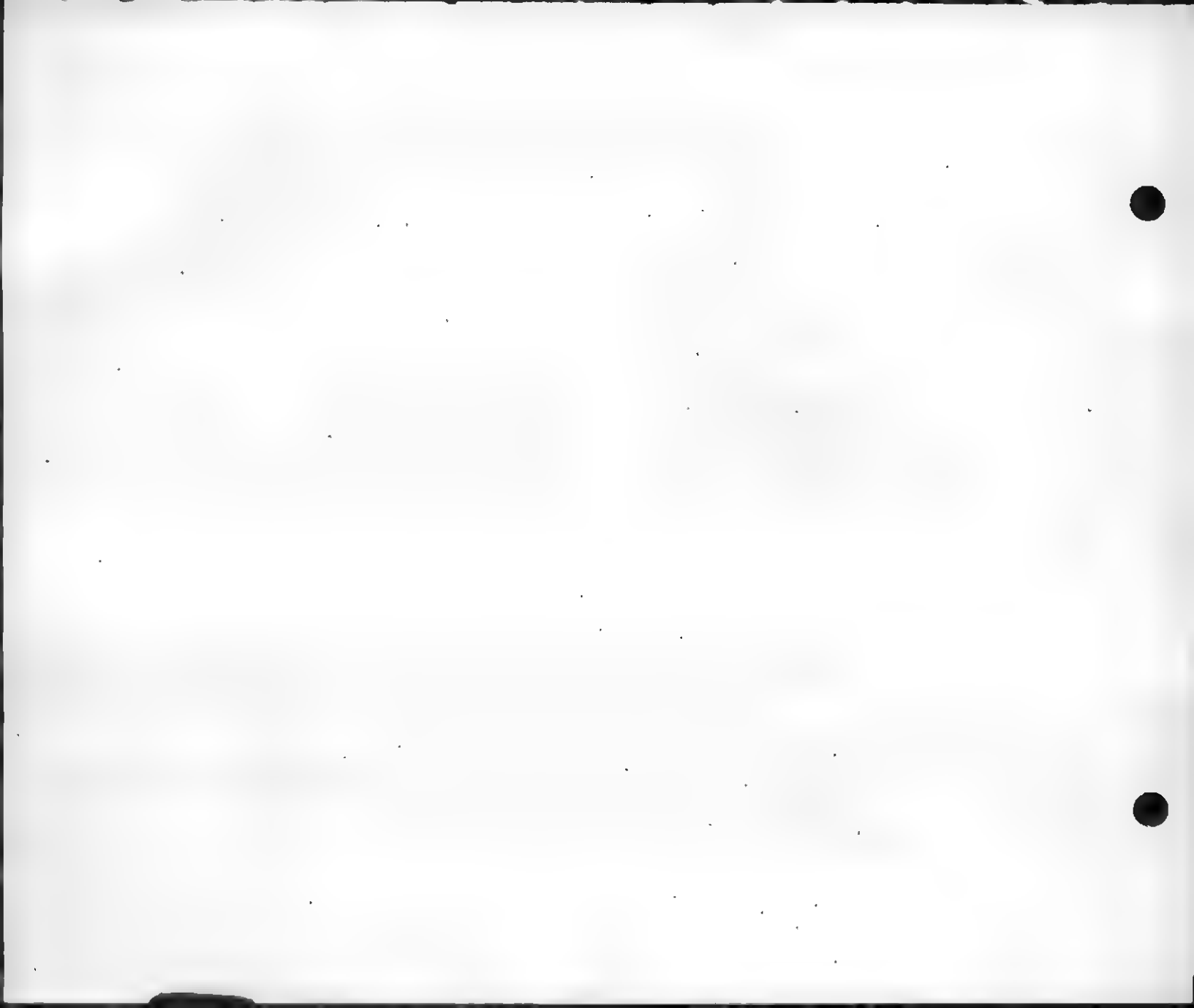
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>442 W. Church St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles William Hecker, Jr.</u>	4. DATE OF DEATH Month Day Year <u>February 3 19 66</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 19, 1958</u>
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles William Hecker, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Lee Straubs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles W. Hecker Sr.</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> <u>7/20</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Crushed Chest</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Was struck by a large truck.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2-3- 19 66</u> <u>1:33 p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hagerstown, Washington, Md.</u>		20f. <u>Alley North of W. Franklin St.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		22. DATE SIGNED <u>Feb. 4, 1966</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/7/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (city, town or county) (State) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR <u>Wm. A. Hunt</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>f. l. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forestown</u>				c. LENGTH OF STAY IN 1b <u>P.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagers' town</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forestown</u>						d. STREET ADDRESS <u>27 W. Taylor Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charlotte May Henson</u>			First Middle Last			4. DATE OF DEATH <u>Feb. 22 1966</u>			Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 11 1901</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		
13. FATHER'S NAME <u>Low Bradley Nave</u>						14. MOTHER'S MAIDEN NAME <u>Ellen Nave</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>				16. SOCIAL SECURITY NO. <u>216 22 7516</u>		17. INFORMANT <u>Mr. J. H. Seachley</u>		Address <u>Forestown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4301</u> DUE TO (b) <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Circulatory Disturbance</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 12, 1966</u> to <u>Feb 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 12, 1966</u> , and that death occurred at <u>4:10</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>J. H. Seachley</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. Seachley</u>						22b. DATE SIGNED <u>2/23/66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forestown</u>		23d. LOCATION (City, town or county) (State) <u>Forestown, Md.</u>		24. FUNERAL DIRECTOR <u>Charles Judge</u>			
25a. REC'D BY REGISTRAR <u>FEB 28 1966</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

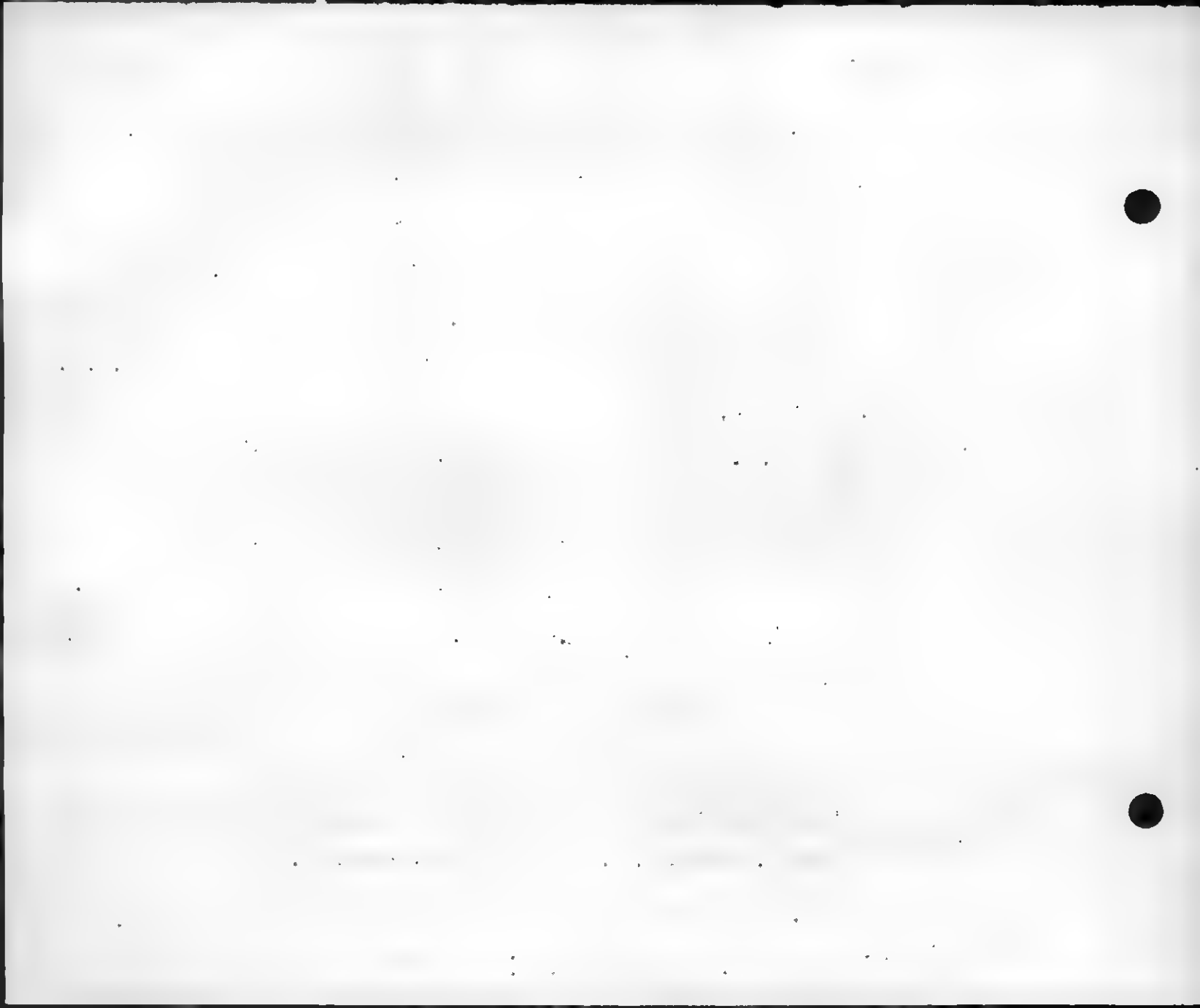


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN ID <b>3 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>343 Central Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Early</b> Middle <b>Russell</b> Last <b>Hicks</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1893</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hicksville Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rev. Cadmus M. Hicks</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dennis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-36-3833</b>	
17. INFORMANT <b>Mrs Agnes Gearhart</b>		Address <b>343 Central Ave Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetic Glomerulonephritis</b> (c) <b>Diabetes Mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>5 yrs</b> <b>7 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity - Congestive Heart Failure</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1966</b> to <b>Feb 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>2-27-66</b> , and that death occurred at <b>6:40 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John C. Morton, M.D.</b>		22b. DATE SIGNED <b>3-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Morton, M.D.</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 2, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Broadford, Md.</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>DATE 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

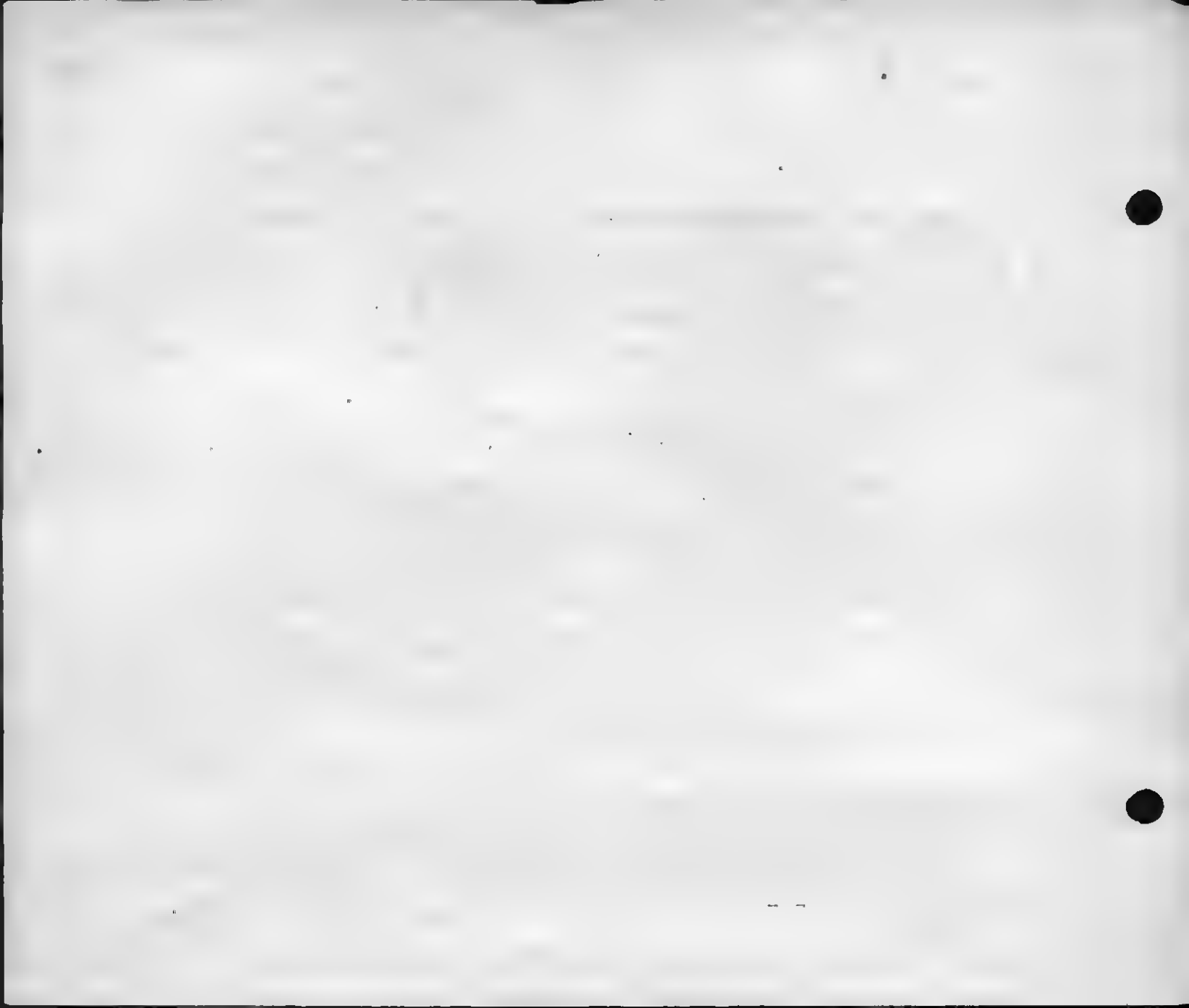
## CERTIFICATE OF DEATH

32924

02904

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN lb <u>30yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>317 1/2 N Jonathan Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Frances Alice Keats</u>				<b>4. DATE OF DEATH</b> Last <u>Feb</u> Month <u>4</u> Day <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec 12 1913</u>	
9. AGE (In years last birth day) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
10a. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Keedysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Roy Keats</u>				14. MOTHER'S MAIDEN NAME <u>Lottie E. Keats</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-16-0867</u>			
17. INFORMANT Address <u>Mrs. Edward Brown 308 N. Jonathan St.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> DUE TO (b) <u>Origin undetermined</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/9/65</u> to <u>2/4/66</u> , that (I) (we) last saw the deceased alive on <u>2/4/66</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald E. Martin</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald E. Martin M.D.</u>				22d. ADDRESS <u>418 North Potomac St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-8-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson Jr. Hagerstown Md.</u>				ADDRESS <u>  </u>		25a. REC'D BY REGISTRAR DATE <u>FEB 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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FOR STATE  
HEALTH DEPT.

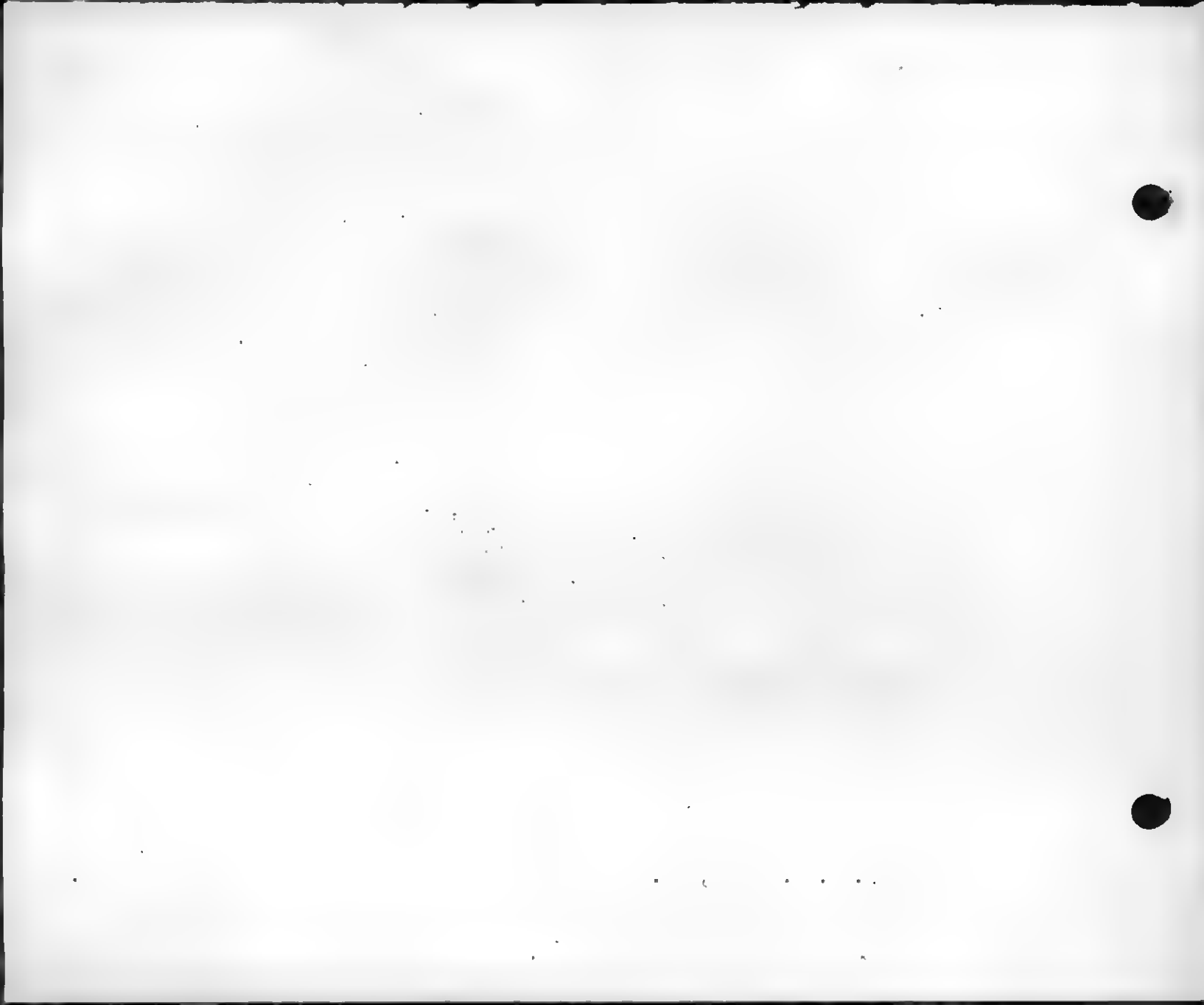
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02005

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN ID 30 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1300 Rose Hill Ave				d. STREET ADDRESS 1300 Rose Hill Ave	
3. NAME OF DECEASED (Type or print) LUTHER ISAAC KEEFER		First Middle Last		4. DATE OF DEATH Feb 5 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 25 1893	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Mercersburg Franklin Co.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Keefer		14. MOTHER'S MAIDEN NAME Mary Hornbaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT Mrs Emma L. Keefer 1300 Rose Hill Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis, Severe With Intramural + / Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hemorrhage Anterior Descending (b) Chronic Pyelonephritis DUE TO Hydronephrosis, Bilateral (c) Cardiac Hypertrophy				INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2-7-66	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (city, town or county) Hagerstown Wash Co Md		23e. LOCATION (city, town or county) Hagerstown Wash Co Md		23f. LOCATION (city, town or county) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew R. Corbin Hagerstown Md.		25a. REC'D BY REGISTRAR FEB 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



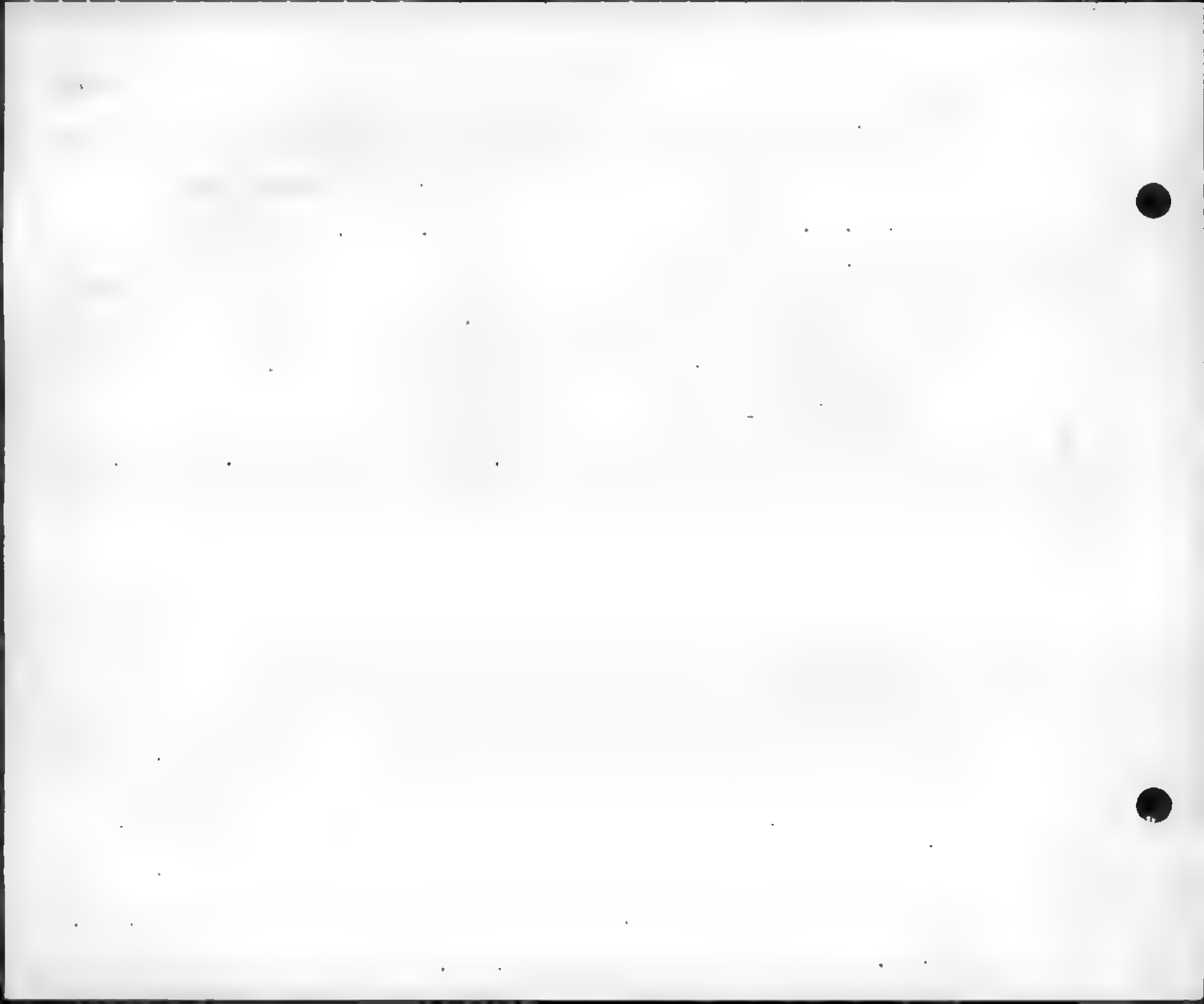
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R. F. D. # 1</b>		e. STREET ADDRESS <b>R. F. D. # 1</b>	
3. NAME OF DECEASED (Type or print) <b>NAOMIA ELIZABETH KLINE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Aug. 2, 1901</b>
9. AGE (In years last birthday) yrs <b>64</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wolfsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Will Williams</b>		14. MOTHER'S MAIDEN NAME <b>Anna Witmer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-24-5814</b>	
17. INFORMANT <b>J. Russell Kline Hag. Md. Rt. 1</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular Failure</b> DUE TO <b>Myocardial Infarction</b> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/4/66</b> , 19 <b>66</b> , to <b>2/5/66</b> , that (I) (we) last saw the deceased alive on <b>2/4/66</b> , 19 <b>66</b> , and that death occurred at <b>2/5/66</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Louis G. Groth</b>		22b. DATE SIGNED <b>2/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Louis G. Groth</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-8-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Smithsburg, Md.</b>
24. FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 10 1966</b>	



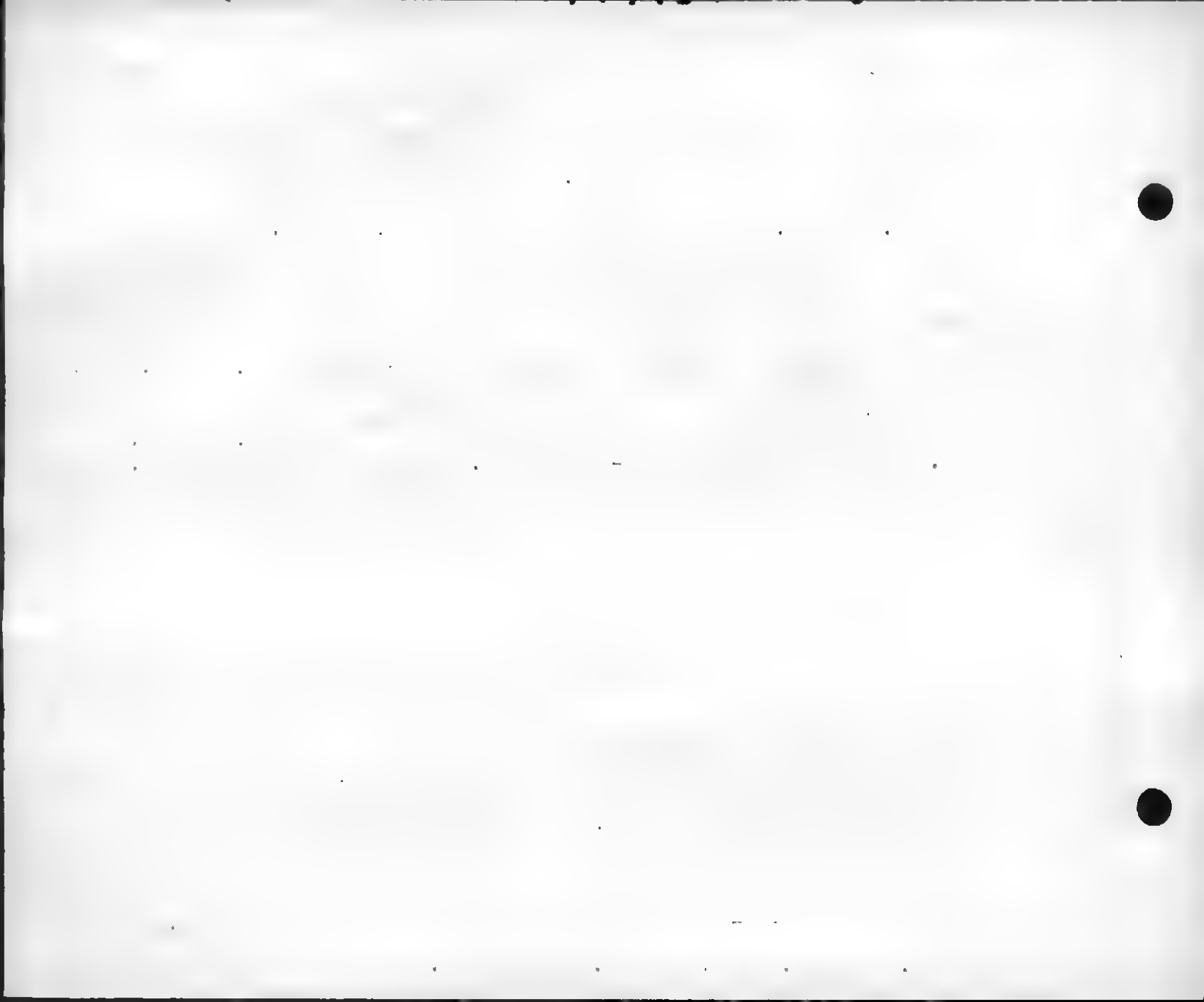
**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		c. LENGTH OF STAY in 1b <b>36 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>105 St. Paul St.</b>		d. STREET ADDRESS <b>105 St. Paul St.</b>	
3 NAME OF DECEASED (Type or print) First <b>Winton</b> Middle <b>Ernest</b> Last <b>Knobe</b>		4 DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 1, 1906</b>
9 AGE (In years last birthday) <b>59</b> yrs		10 UNDER 1 YEAR Months <b>10</b> Days <b>27</b> Hours <b></b> Min. <b></b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Shoe Manufacturing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Rohrersville, Md.</b>		12 C TIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Howard Knobe</b>		14 MOTHER'S MAIDEN NAME <b>Alta Haller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16 SOCIAL SECURITY NO <b>214-09-5713HA</b>	
17 INFORMANT <b>Mrs. Ellen Knobe, Boonsboro, Md.</b>		105 St. Paul St. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1969 Carcinoma of bone</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 5, 1965</b> to <b>Feb 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 23, 1966</b> , and that death occurred at <b>9:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>G. W. HeVan</i>		22b. DATE SIGNED <b>March 2, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. HeVan</b>		22d. ADDRESS <b>Boonsboro, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3- 3- 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>
24 FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main S., Boonsboro, Md.</b>		25a REC'D BY REGISTRAR <b>MAR 4 1966</b>	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



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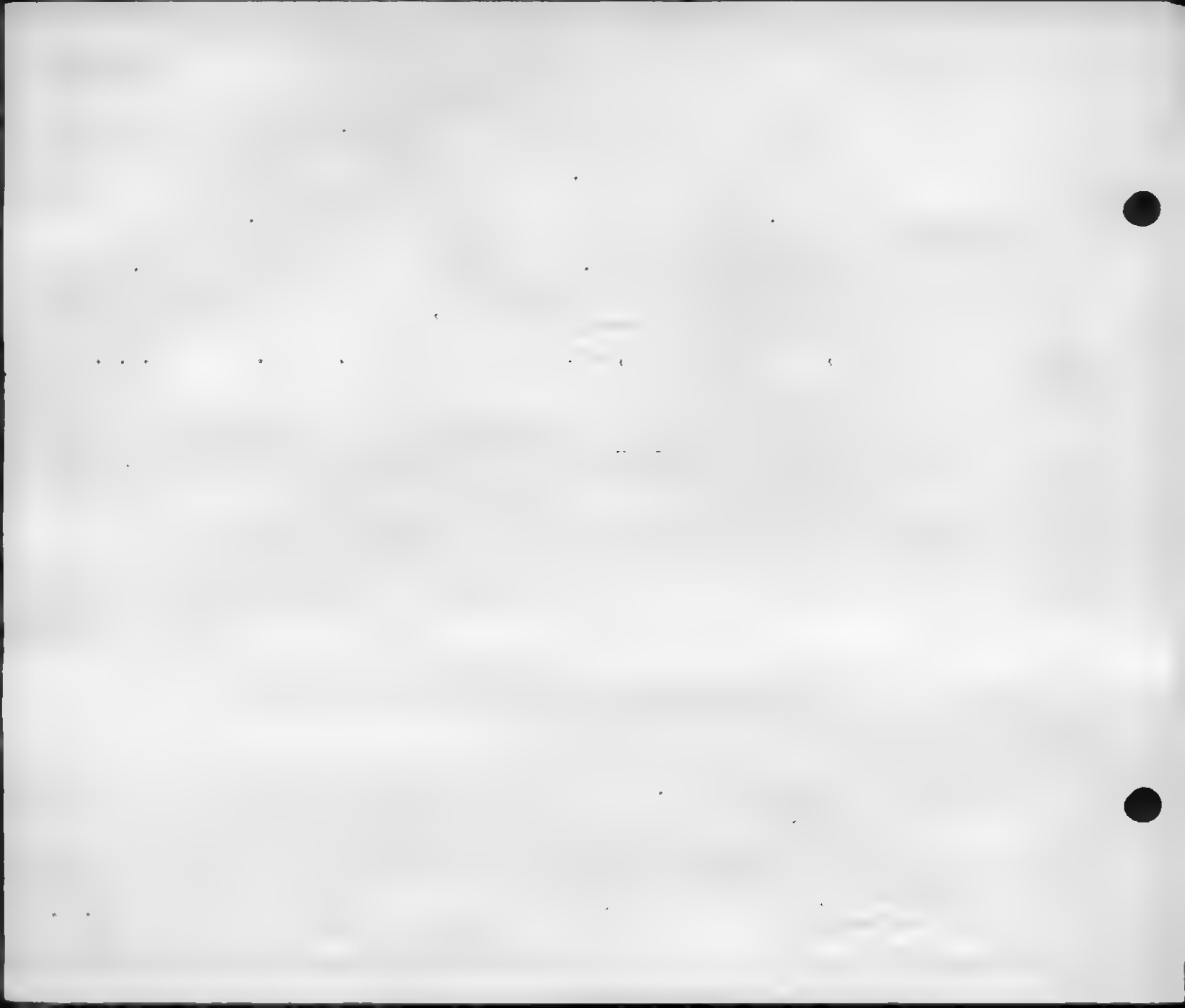
1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN lb <u>18 HRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON CO. HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>FRANKLIN</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENCASTLE</u> d. STREET ADDRESS <u>502 EAST BALTIMORE ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>HARRY</u> <u>C.</u> <u>KRINER</u>		<b>4. DATE OF DEATH</b> <u>FEBRUARY</u> <u>4,</u> <u>1966</u>	
<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JUNE 13, 1881</u> <b>9. AGE</b> (In years last birthday) <u>84</u> yrs	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FRUIT GROWER, DEALER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>ORCHARD, LIVESTOCK</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>FRANKLIN CO. PENNA.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>JONAS KRINER</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>EMMA ELLIOTT</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>198-30-4387</u> <b>17. INFORMANT</b> <u>Ray R. Kriner, Dayton, New Jersey</u> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>ARTERIO-SCLEROSIS (GENERALIZED)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug</u> <u>1964</u> <b>to</b> <u>Feb.</u> <u>1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3 FEB</u> <u>1966</u> <b>and that death occurred at</b> <u>5:30</u> <b>M.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>[Signature]</u> M.D.		<b>22b. DATE SIGNED</b> <u>5 Feb 66</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>P F WEBSTER</u>		<b>22d. ADDRESS</b> <u>GREENCASTLE, PA.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>2/6/1966</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Greencastle, Franklin Co. Pa.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u> ADDRESS <u>[Address]</u>		<b>25a. REC'D BY REGISTRAR</b> <u>[Signature]</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	





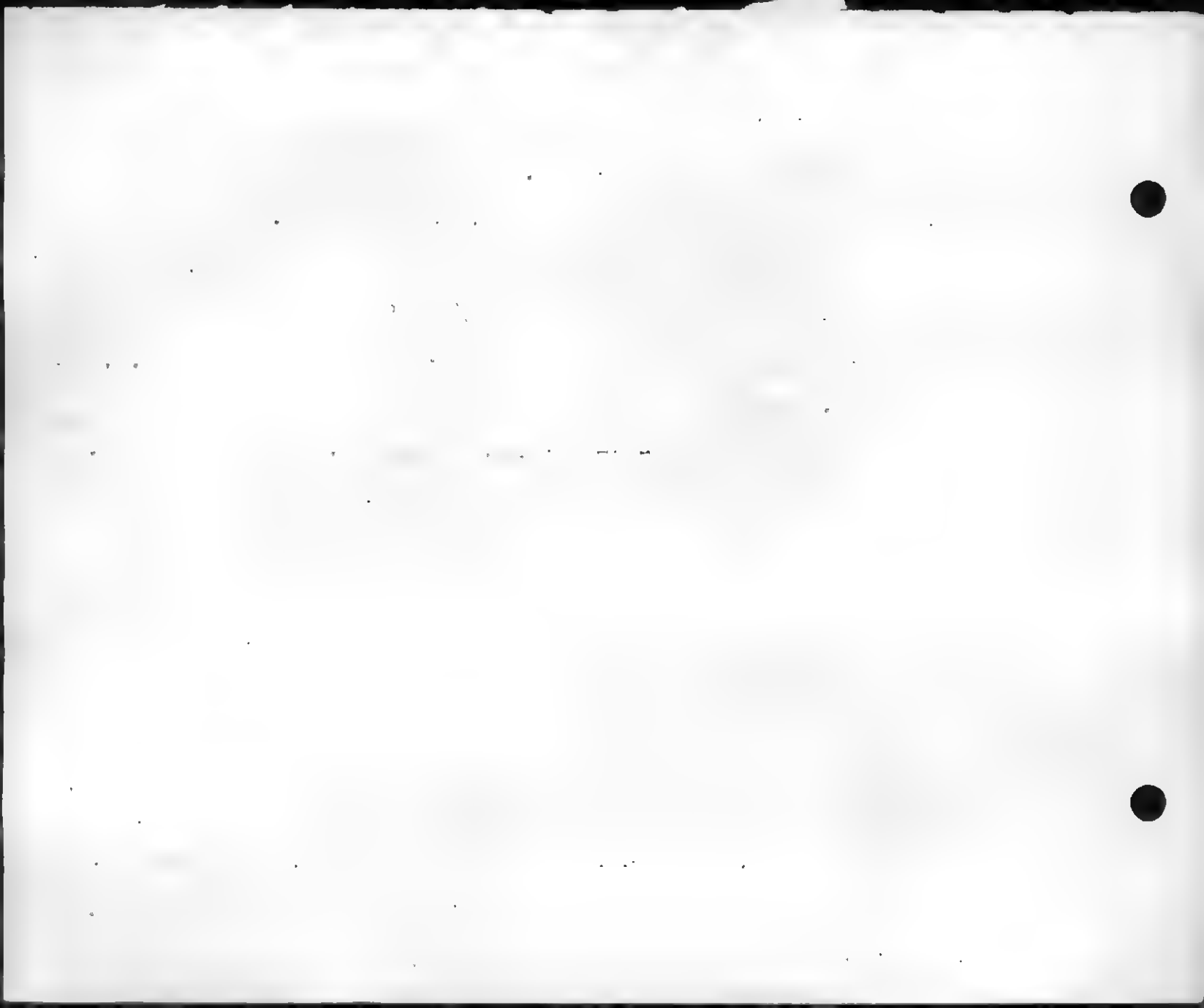
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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																					
<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>30 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>1700 GORDON RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARIE</b> Middle <b>JOYCE</b> Last <b>LEHMAN</b>			<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>21</b> Year <b>1966</b>		<b>5. SEX</b> <b>FEMALE</b>			<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
<b>8. DATE OF BIRTH</b> <b>2/21/1908</b>			<b>9. AGE</b> (In years last birthday) <b>58</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>HOME</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MICHIGAN</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>13. FATHER'S NAME</b> <b>FRANK C. KAETZEL</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>BESSIE WELLS</b>																
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> <b>214-09-0789</b>		<b>17. INFORMANT</b> <b>MR. RICHARD H. LEHMAN</b>			<b>Address</b> <b>HAGERSTOWN MD.</b>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Pulmonary Embolism, Massive</b> <b>465X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>minutes</b>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Acute Cholecystitis with Cholelithiasis (Operated 12/5/66)</b>																					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)														
<b>21. I certify that (I) (this hospital) attended the deceased from 3-31-1948 to 2-21-1966, that (I) last saw the deceased alive on 2-21-1966, and that death occurred at 10 P.M. from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dalton M. Welty</b> I.D.					<b>22b. DATE SIGNED</b> <b>2/23/66</b>		<b>22d. ADDRESS</b> <b>998 Potomac Ave., Hagerstown, Md.</b>														
<b>23a. BURIAL, CREMATION, or other disposal (Specify)</b> <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>2/24/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>CHURCH OF BRETHERN</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>BROWNSVILLE MD.</b>														
<b>24. FUNERAL DIRECTOR</b> <b>W. J. Harman, Hagerstown, Md.</b>					<b>25a. REC'D BY REGISTRAR</b> <b>FEB 23 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b>														

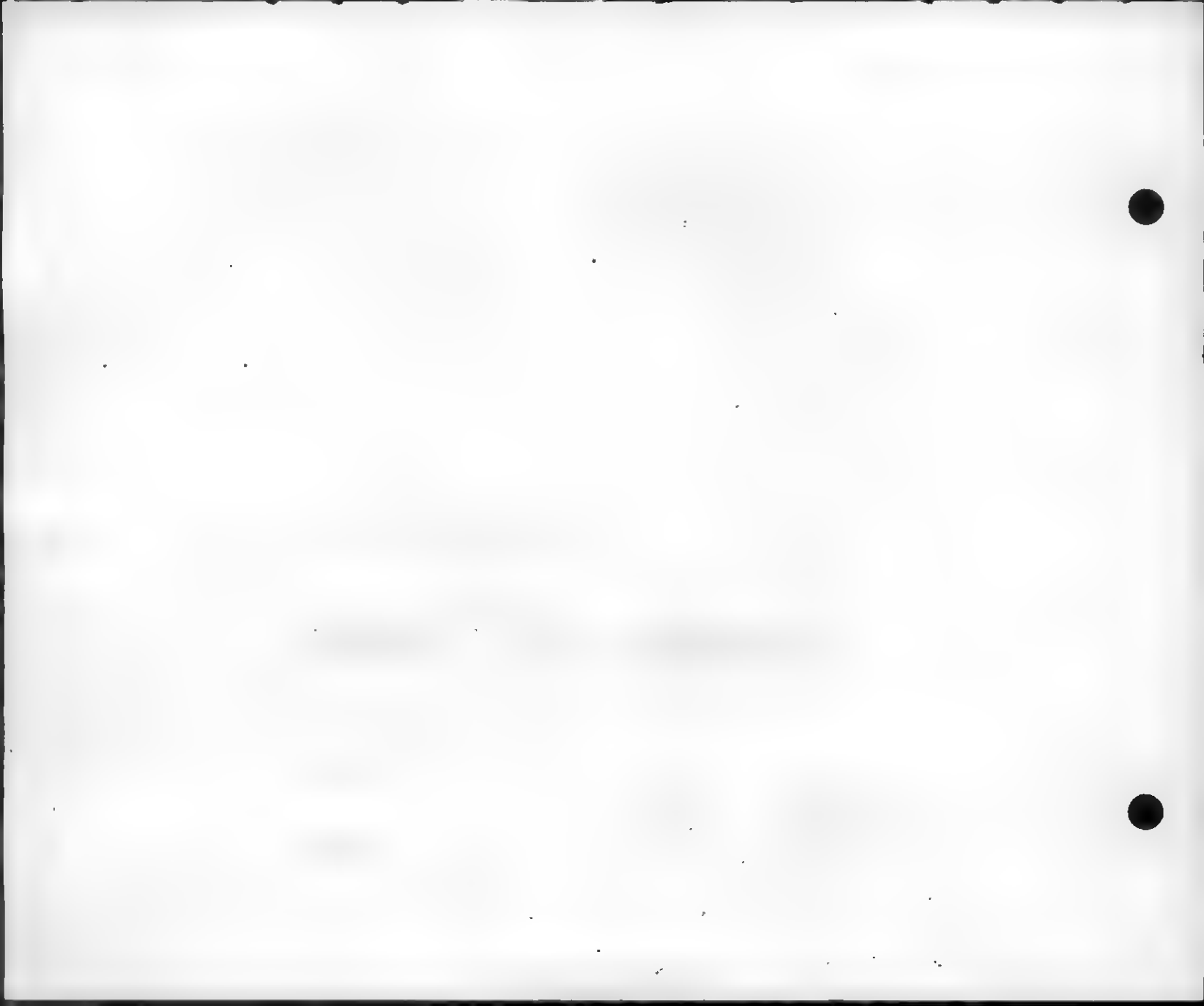


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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>					d. STREET ADDRESS <u>5113 Brinkley Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas A. Lloyd</u>					4. DATE OF DEATH <u>Feb. 23 1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/4/81</u>		9. AGE (in years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas A. Lloyd</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Lennett</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>578 12 5190</u>		17. INFORMANT <u>Mrs Wilbur Maines</u>			Address <u>Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF THE PROSTATE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DEHYDRATION AND MALNUTRITION</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>2 1/2 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2-18, 1966</u> , to <u>2-23, 1966</u> , that (I) (we) last saw the deceased alive on <u>2-23, 1966</u> , and that death occurred at <u>12:4 M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Efren A. Ramirez</u>					22b. DATE SIGNED <u>2-23-66</u>		22c. PHYSICIAN'S NAME (Type) <u>EFREN A. RAMIREZ</u>		
22d. ADDRESS <u>1500 PENN. AVE, HAGERSTOWN MD.</u>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/26/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Md</u>		
24. FUNERAL DIRECTOR <u>W. Mattingly</u>					25a. REC'D BY REGISTRAR <u>131-117 S.E. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

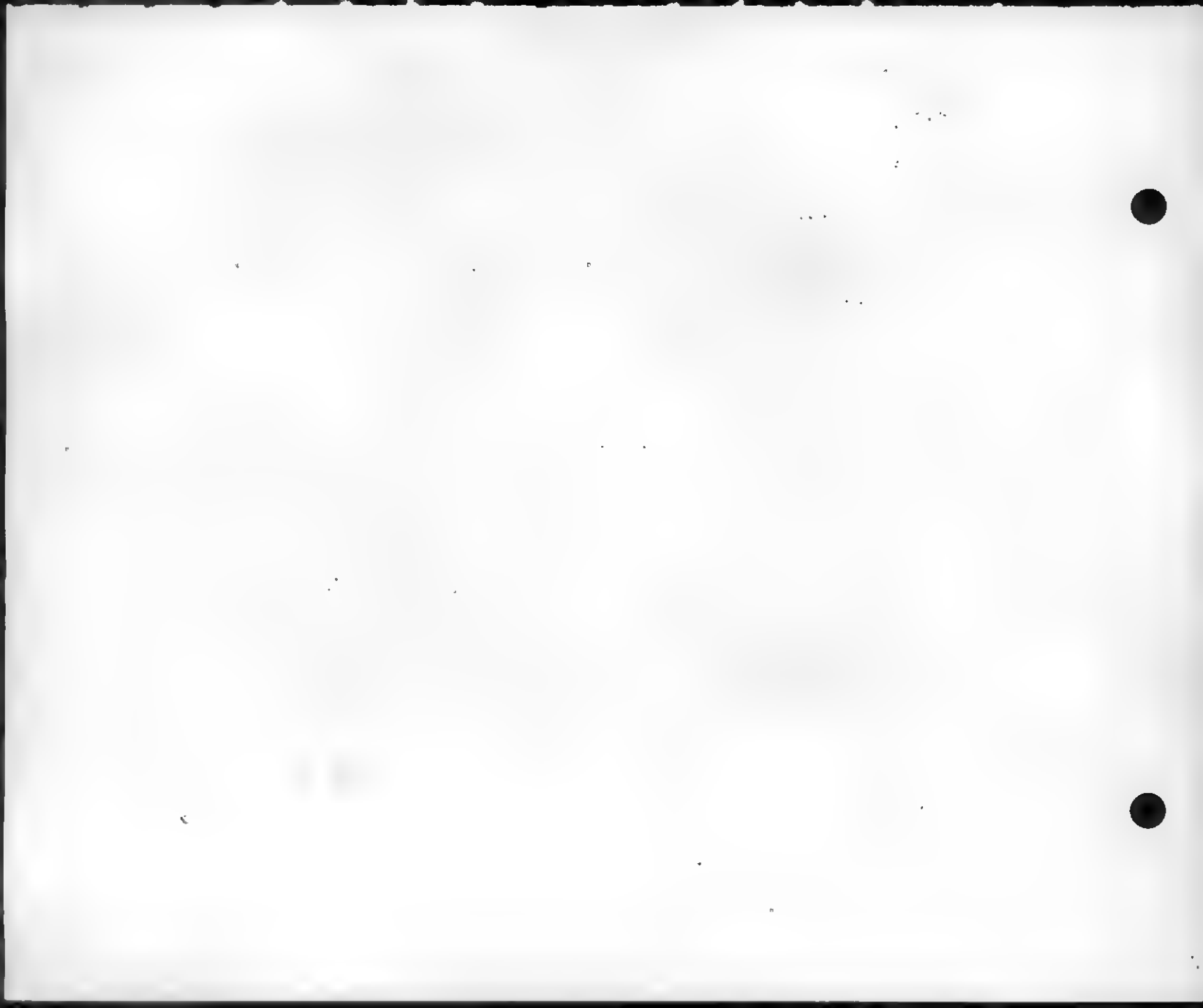


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Burkittsville,		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Armstead		First U.		Middle Magaha		Last Magaha		4. DATE OF DEATH Feb. 3 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1873		9. AGE (in years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Franklin Magaha		14. MOTHER'S MAIDEN NAME Julia Bond		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-36-0409		17. INFORMANT Louise Magaha		Address Burkittsville, Md.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) <u>Adenocarcinoma prostate with metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 6:00 PM, from the causes and on the date stated above.												22a. SIGNATURE <u>John D. Dringhouse</u> M.D.				22b. DATE SIGNED 2-4-66				22c. PHYSICIAN'S NAME (Type) Gladhill Co.				22d. ADDRESS Middletown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 6, 1966				23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION (City, town or county) (State) Burkittsville, Md.				25a. REC'D BY REGISTRAR FEB 8 1966				25b. REGISTRAR'S SIGNATURE J. R. Judge											



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Penna</b>		b. COUNTY <b>York</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN ID <b>14 Yrs 3 Mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Homewood Church Home Inc</b>				d. STREET ADDRESS <b>217 Broadway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IDA</b>		First <b>SHUE</b>		Last <b>LAJOR</b>		4. DATE Month <b>Feby</b> 3 1968 19	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 10 1880</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Glenville York Co Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13. FATHER'S NAME <b>Zacharias Shue</b>				14. MOTHER'S MAIDEN NAME <b>Emaline Tracey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mark G. Wagner</b>				Address <b>2570 Virginia Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Lymphoma</b> <b>2002</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 15, 1963</b> to <b>Feb 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 1, 1966</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert P. Conrad</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-4-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>				22d. ADDRESS <b>137 W. Washington Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feby 7 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Jacobs Stone Ch Cem.</b>		23d. LOCATION (City, town or county) (State) <b>York Broadbeck Co Pa</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>				ADDRESS <b>Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1968</b>	
				25b. REGISTRAR'S SIGNATURE			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

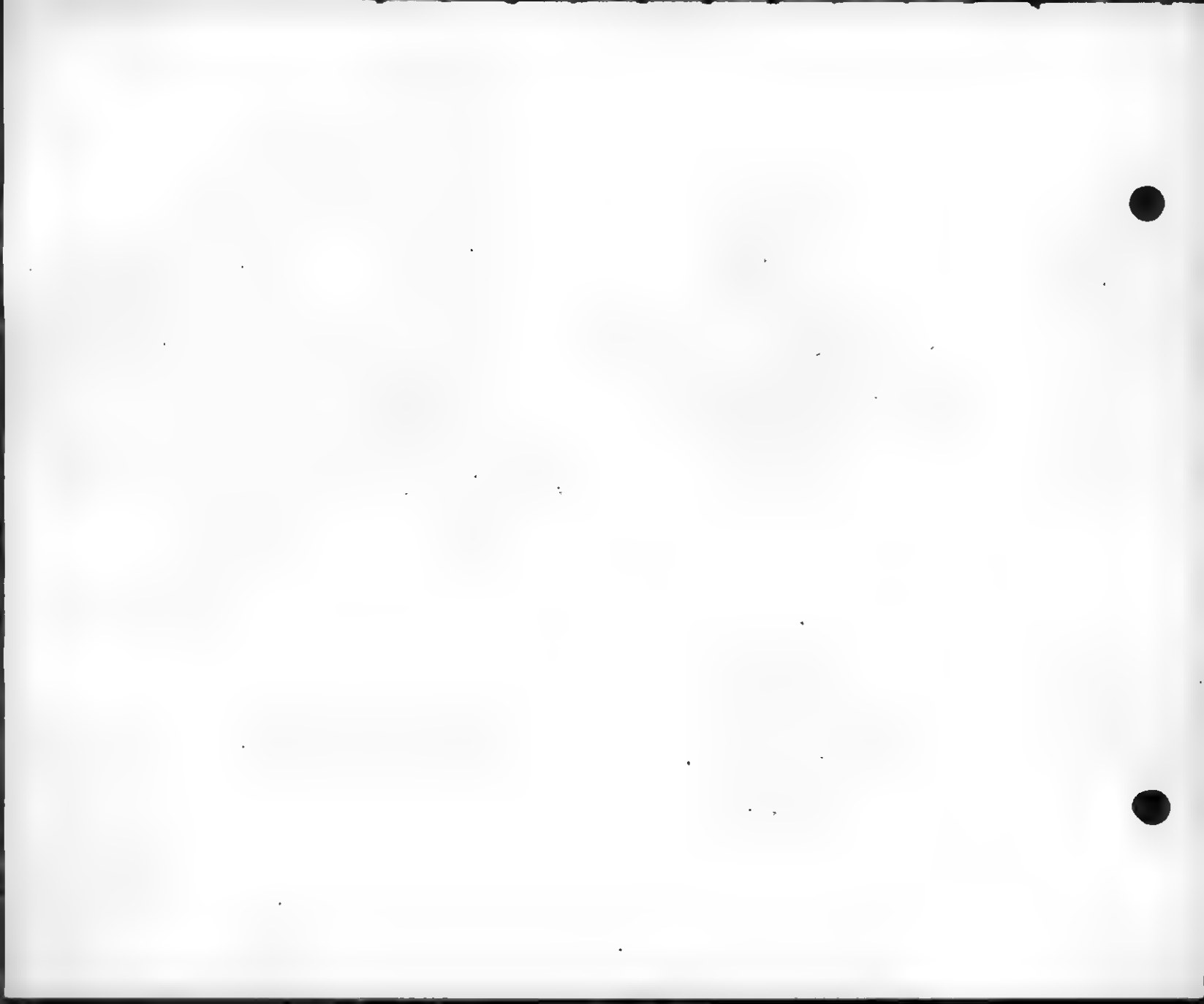
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>1 yr. 2 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Waynesboro</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> d. STREET ADDRESS <u>84 W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>C</u> Last <u>MANON</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR, FINDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Greencastle, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Cantner</u>		14. MOTHER'S MAIDEN NAME <u>Sally Foreman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>265-60-0524</u>	
17. INFORMANT <u>Mrs. Elsie Boykin</u>		Address <u>Waynesboro Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Atherosclerosis</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Febr 11</u> , 19 <u>66</u> to <u>Febr 13</u> , 19 <u>66</u> that (2) (we) last saw the deceased alive on <u>Febr 11</u> , 19 <u>66</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>2-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Feb. 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	23d. LOCATION (City, town or county) (State) <u>Waynesboro Franklin Co. Pa.</u>
24. FUNERAL DIRECTOR <u>Walter Z. Grove, Waynesboro Pa.</u>		25a. REC'D BY REGISTRAR <u>F.B. 16 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. B. J. ye</u>	

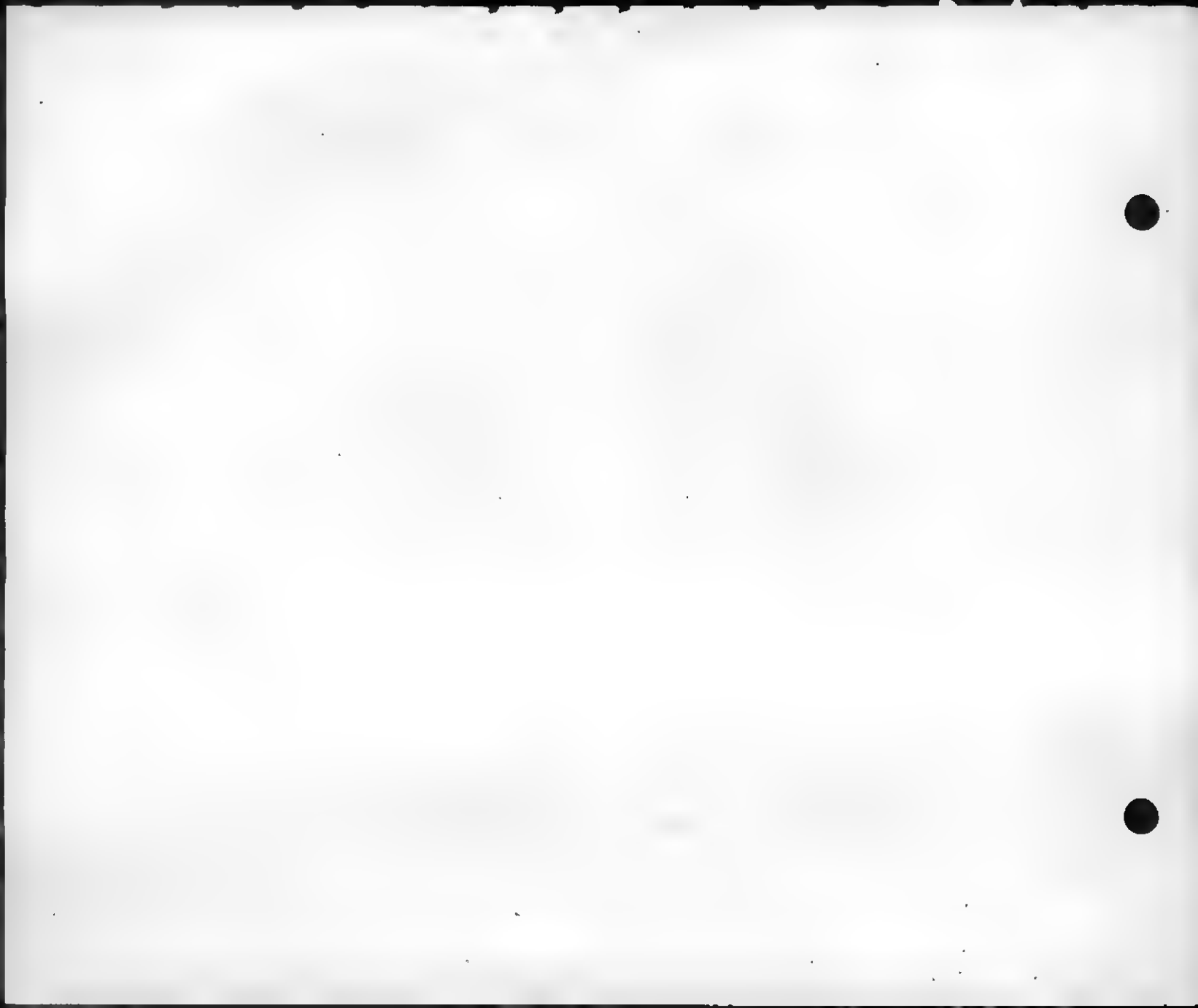
MEDICAL CERTIFICATION



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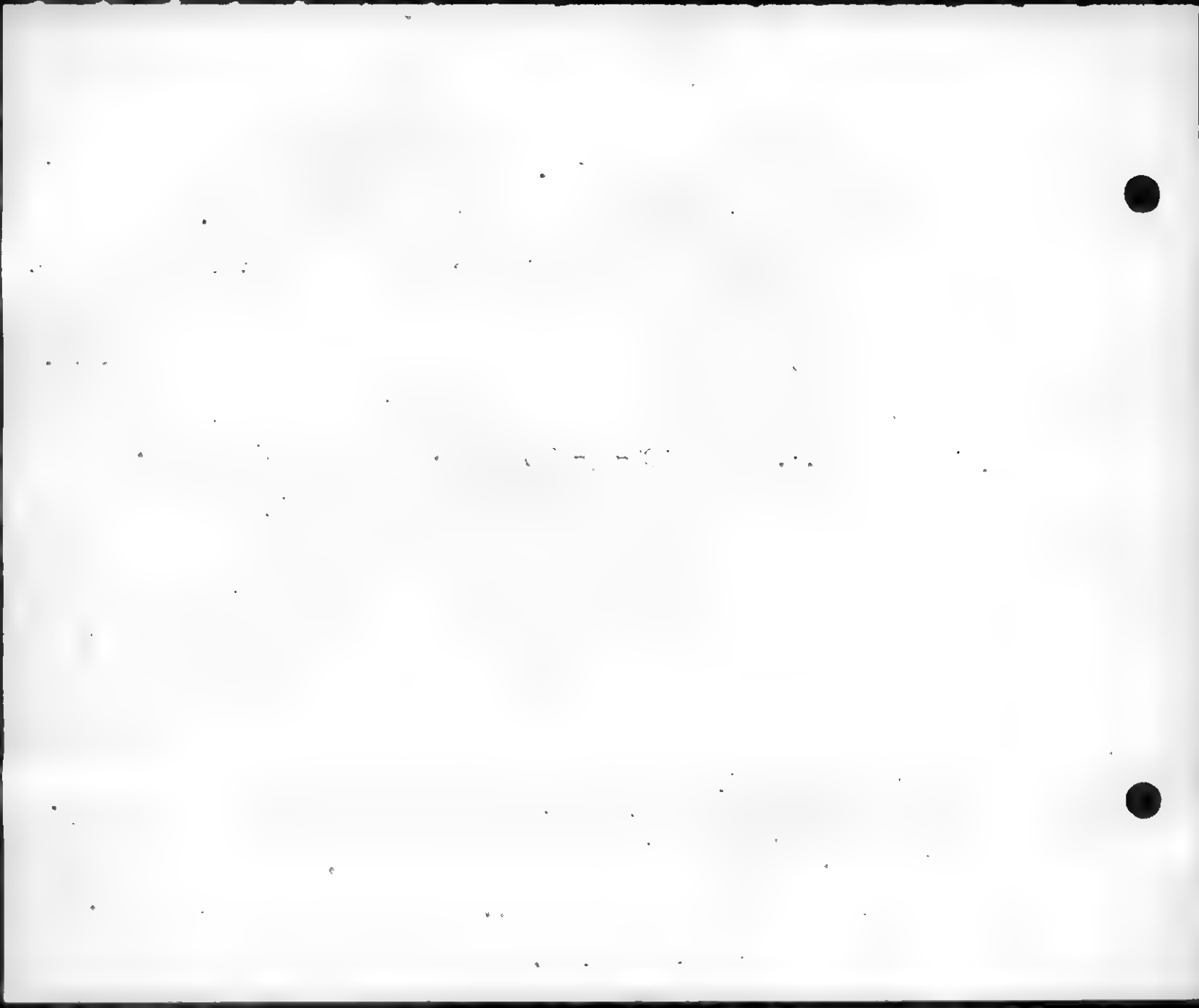
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>!</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHAPEL OAKS</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WESTERN MARYLAND STATE HOSP.</u>					d. STREET ADDRESS <u>5406 NASH STREET</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OTELIA</u> Middle <u>G.</u> Last <u>McCollough</u>			6. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1966</u>								
5. SEX <u>F</u>		6. COLOR OR RACE <u>Negroes</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/10/27</u>		9. AGE (In years last birthday) <u>38</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSES H.D. HOSPITAL</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>CHARLES G. FERGUSON</u>					14. MOTHER'S MAIDEN NAME <u>SARAH L. PIERCE</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>232-38-0458</u>		17. INFORMANT <u>William McCollough</u>			Address <u>5406 NASH ST. Chapel Oaks</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO (b) <u>Fibrosarcoma, Left Leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>Not known</u> <u>10 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>66</u> to <u>2/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>66</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/20/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR RIEGO</u>					22d. ADDRESS <u>1500 Penna. Avenue Hagerstown</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>				
24. FUNERAL DIRECTOR <u>John T. Stewart Jr.</u>					ADDRESS <u>Stewart Funeral Home 4001 Benning Rd.,</u>		25a. REC'D BY REGISTRAR <u>Feb 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02935						02915					
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>9 MRS.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				d. STREET ADDRESS <b>1324 HAMILTON BLVD.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>PAUL DONALDSON McCOY</b>			First Middle Last			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>16</b> Year <b>1966</b>			5. AGE (In years last birthday) <b>43 yrs.</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/11/1923</b>		9. AGE (In years last birthday) <b>43 yrs.</b>		IF UNDER 1 YEAR: Months <b>1</b> Days <b>16</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOCTOR OF DENTISTRY</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>PAUL McCOY</b>						14. MOTHER'S MAIDEN NAME <b>NELLIE HANNA</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>W.W.#2</b>		17. INFORMANT <b>MRS. JOANNE McCOY MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> + x o i DUE TO (b) <b>Coronary insuff.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerotic cardiac dis.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>17 Oct</b> , 19 <b>57</b> , to <b>16 Feb</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>16 Feb</b> , 19 <b>66</b> , and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Richard T. Binford</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>18 Feb 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD</b>						22d. ADDRESS <b>HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/19/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PHILOS CEM.</b>				23d. LOCATION (City, town or county) (State) <b>WESTERNPORT MD.</b>			
24. FUNERAL DIRECTOR <b>W. J. McCrement, Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

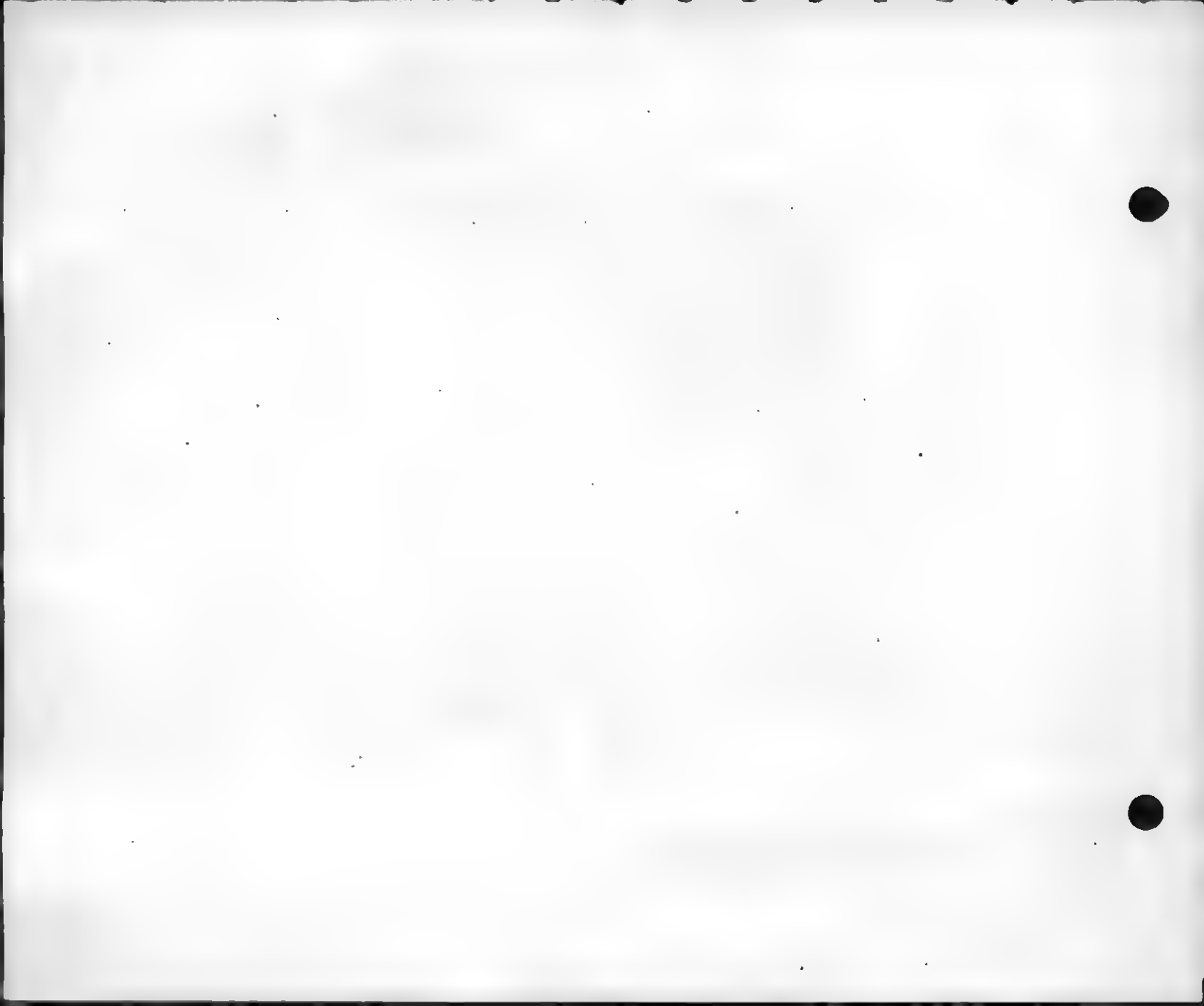


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Washington Co</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown - Md</i>		c. LENGTH OF STAY IN MD		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Maryland State Hospital - Hagerstown Md</i>						d. STREET ADDRESS <i>815-62nd Pl. Cedar N.E.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Thelma Alberta Nelson</i>		4. DATE OF DEATH <i>Feb. 19 1966</i>		5. SEX <i>F</i>		6. COLOR OR RACE <i>Negress</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/18/24</i>	
9. AGE (In years last birthday) <i>42</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>		13. FATHER'S NAME <i>Thomas Mitchell</i>	
14. MOTHER'S MAIDEN NAME <i>Emma Ellis</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Delores Nelson Boomer</i>		Address <i>(Daughter)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobular Pneumonia</i> DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>6 mos.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>11-2, 1965</i> to <i>2-19, 1966</i> , that (I) (we) last saw the deceased alive on <i>2-19 - 1966</i> , and that death occurred at <i>12:40 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>Arthur Riego</i>		22b. DATE SIGNED <i>2/19/66</i>		22c. PHYSICIAN'S NAME (Type) <i>ARTHUR RIEGO</i>		22d. ADDRESS <i>1500 Penna. Ave. Hagerstown, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-23-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial</i>		23d. LOCATION (City, town or county) (State) <i>Lanham P.G.Co. Md</i>		24. FUNERAL DIRECTOR <i>William Spangler - 524-8-St NE - Wash. D.C.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <i>FEB 23 1966</i>		25d. REGISTRAR'S SIGNATURE		25e. DATE		25f. REGISTRAR'S SIGNATURE		25g. DATE	





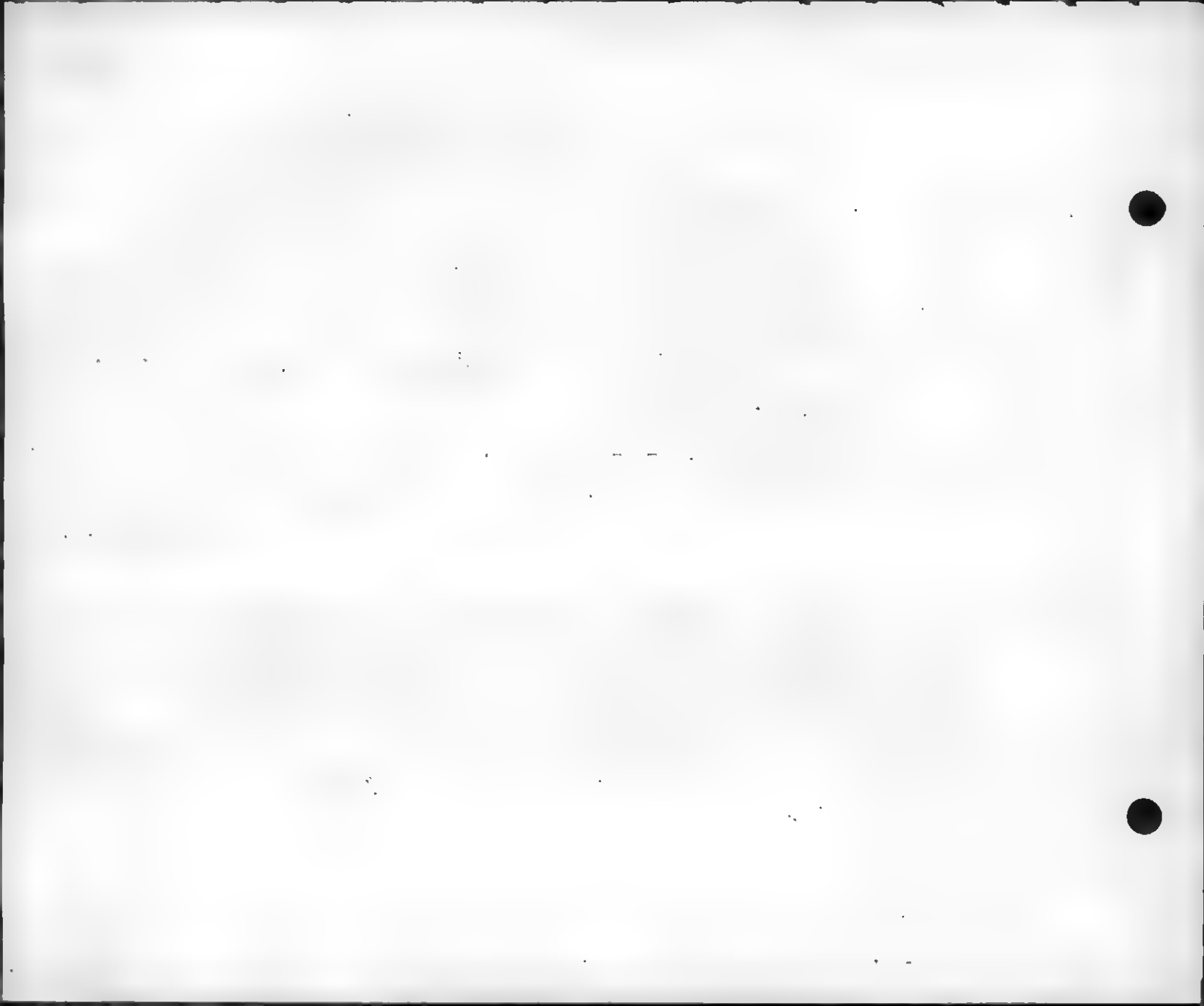
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Route #3- Bedford Road	
c. LENGTH OF STAY IN 1b 5 Months		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pleasant M. Messick		4. DATE OF DEATH Month Feb Day 21 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 9, 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania (Bedford) Co		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Hardman		14. MOTHER'S MAIDEN NAME Alice Mann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 177-32-9952	
17. INFORMANT Mrs. Aubrey A. Chambers		Address Route #3 Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral pneumonia</u> DUE TO (b) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>8 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/13, 1965</u> to <u>2/24, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/24, 1966</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ruth E. Silcox</u>		22b. DATE SIGNED <u>Feb 24 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ruth E. Silcox</u>		22d. ADDRESS <u>1507 Penna. Ave Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF <u>2/24/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Herman Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland Maryland</u>
24. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>		25a. REC'D BY REGISTRAR <u>Feb 24 1966</u>	
Cumberland Maryland 21502		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

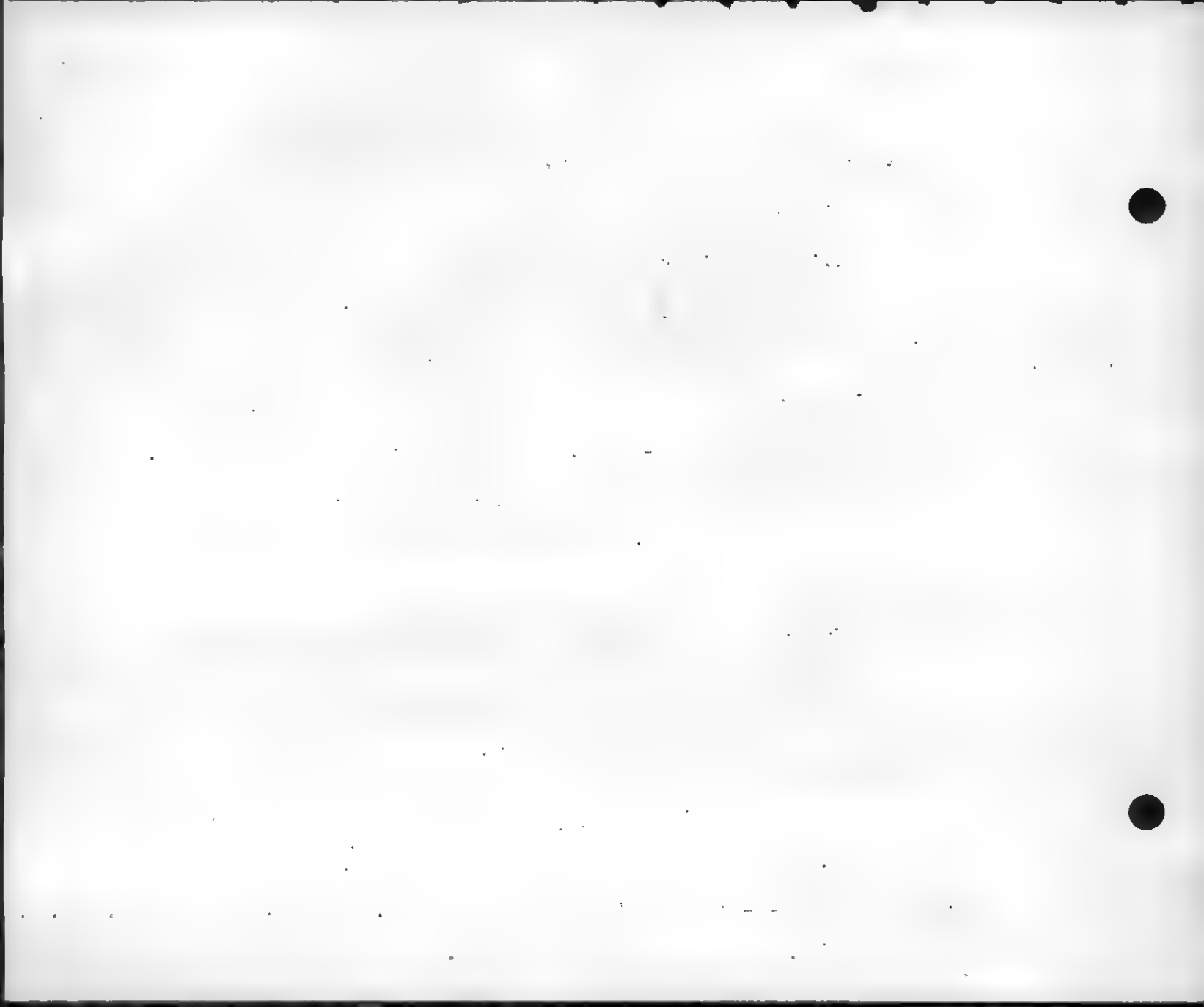


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>9 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>		e. STREET ADDRESS <u>Thurmont</u>	
3. NAME OF DECEASED (Type or print) <u>Maude Catherine Messner</u>		4. DATE OF DEATH <u>Feb. 1, 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1893</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Isanogle</u>		14. MOTHER'S MAIDEN NAME <u>Emma Eicholtz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-03-3923</u>	
17. INFORMANT <u>Grace Baker</u>		Address <u>249 Fred. St. Hagerstown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus (2) old posterior myocardial infarction</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>April 7, 1965</u> , to <u>Feb. 1, 1966</u> , that (1) (we) last saw the deceased alive on <u>Feb. 1, 1966</u> , and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos</u>		22b. DATE SIGNED <u>Feb. 4, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS</u>		22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>United Brethren Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Thurmont Fred. Co. Md</u>
24. FUNERAL DIRECTOR <u>James B. Bager</u>		25a. REC'D BY REGISTRAR <u>Feb 4 1966</u>	
ADDRESS <u>Thurmont, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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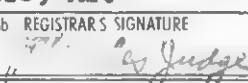
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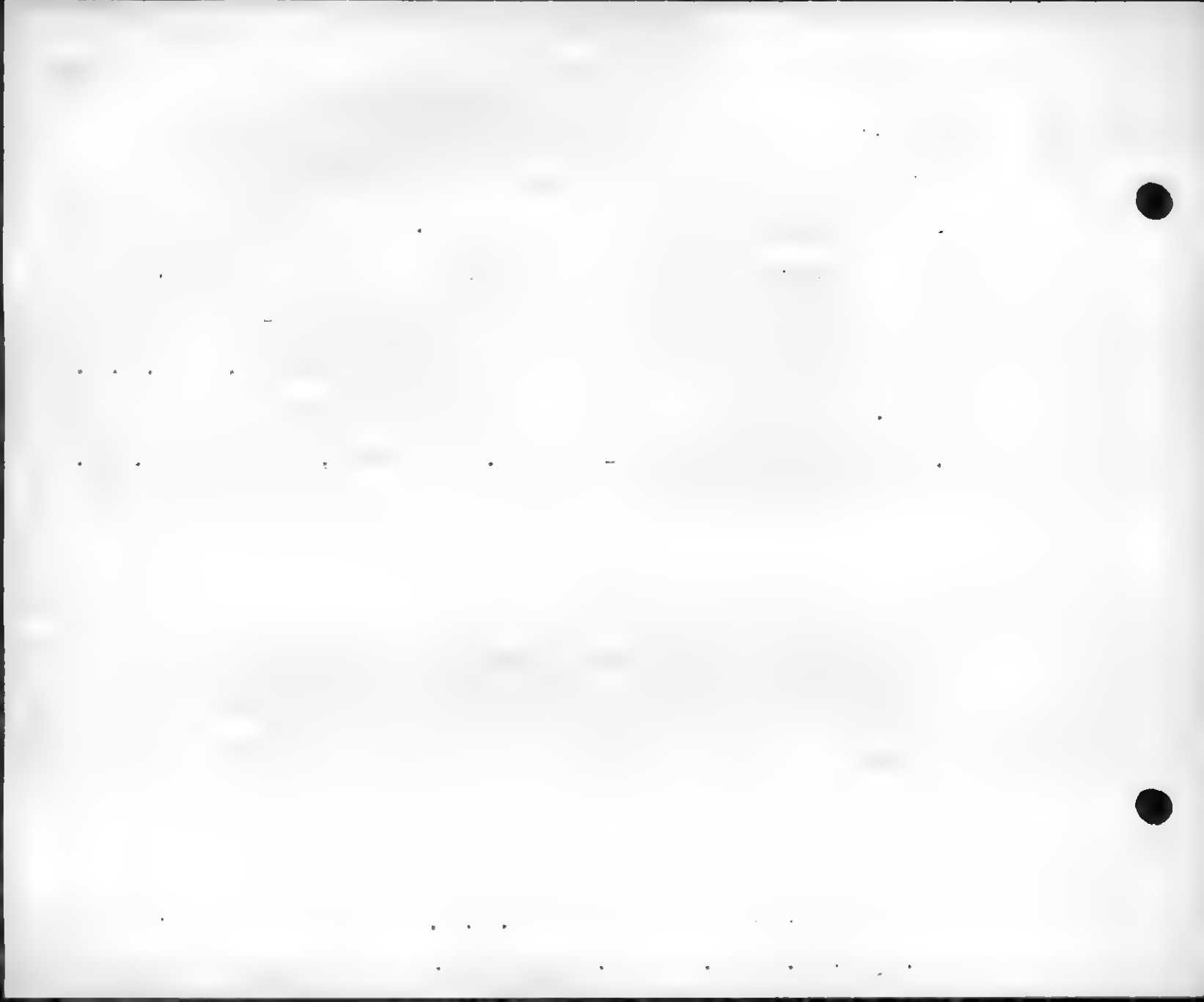
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02033

02019

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY in lb <b>15 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Myersville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Rfd. 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edgar Samuel Naille</b>				4. DATE OF DEATH Month Day Year <b>February 4, 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1890</b>	9. AGE (In years last birthday) <b>75</b> yrs	f. UNDER 1 YEAR Months Days Hours Min <b>8 2</b>		g. UNDER 24 HRS Hours Min <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (County & State or foreign country) <b>Rural Myersville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David H. Naille</b>				14. MOTHER'S MAIDEN NAME <b>Missouri Harshman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>219-12-1879</b>		17. INFORMANT Address <b>Mr. Elvin Naille, Myersville Rfd. 1 Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Stomach</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, Hypertensive C V Disease</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov, 1965</b> , to <b>4 Feb, 1966</b> , that (I) (we) last saw the deceased alive on <b>3 Feb, 1966</b> , and that death occurred at <b>1 A.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED <b>5 Feb 66</b>		22c. PHYSICIAN'S NAME (Type) <b>W. H. FENNER</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-7-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cemetery Myersville E. U. B.</b>		23d. LOCATION (City or Town) (County) (State) <b>Myersville, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D. BY REGISTRAR DATE <b>FEB 8 1966</b>		25b. REGISTRAR'S SIGNATURE 	



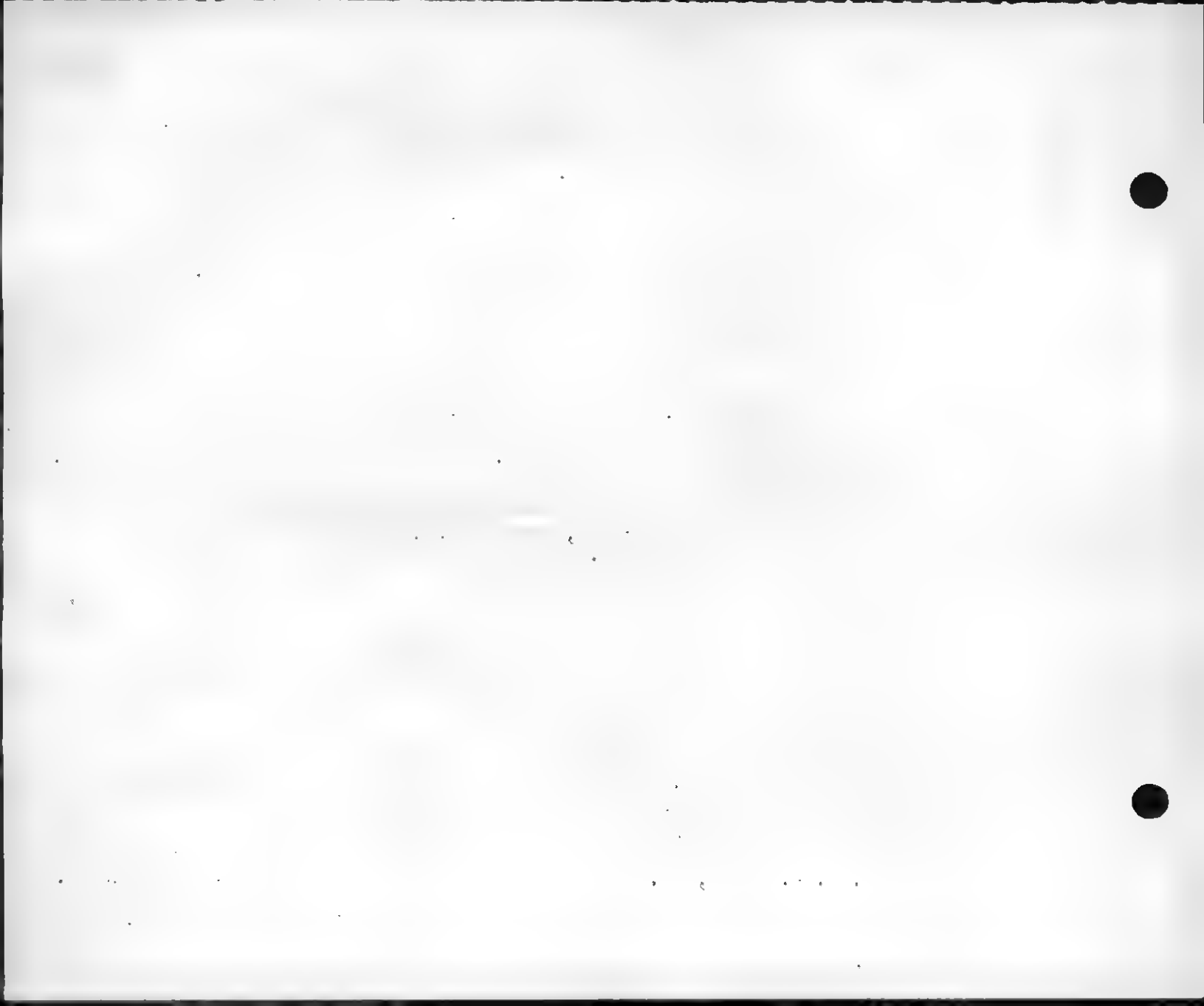
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>son</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>son</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>son</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>son</u>	
3. NAME OF DECEASED (Type or print) First <u>son</u> Middle <u>son</u> Last <u>son</u>		4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>te</u>	6. COLOR OR RACE <u>te</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>74</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Greensboro, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Alfred W. son</u>		14. MOTHER'S MAIDEN NAME <u>Katoran Susan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>114-199781</u>	
17. INFORMANT <u>son</u>		Address <u>son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Of Transverse Colon With Erosion</u> DUE TO <u>Into Stomach, Obstruction, &amp; Massive</u> (b) <u>Hemorrhage.</u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>		22. DATE SIGNED <u>3-2-66</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE DATE <u>MAR 1 1966</u> <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>34 Walnut St.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Luther</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1936</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1910</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>	11. BIRTHPLACE (State or foreign country) <u>Cearfoss, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David L. Palmer</u>	
14. MOTHER'S MAIDEN NAME <u>Miley Cunningham</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>2</u>	
16. SOCIAL SECURITY NO. <u>219-05-2327</u>		17. INFORMANT <u>Donald L. Palmer</u> Address <u>215 James St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Of Gastric Fluid, Marked</u> <u>4 x 01</u> DUE TO <u>Few minutes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis, Moderately Severe</u> DUE TO <u>Several years</u> (c) <u>Coronary Thromboses (Probable) Branch Of Left</u> DUE TO <u>Several years</u> (d) <u>Circumflex Major Twig Of Left Anterior Descending.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		22. DATE SIGNED <u>2-12-66</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 13, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Church Of Brethern</u>		23d. LOCATION (City, town or county) (State) <u>Near Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>	
Address <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 12921. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

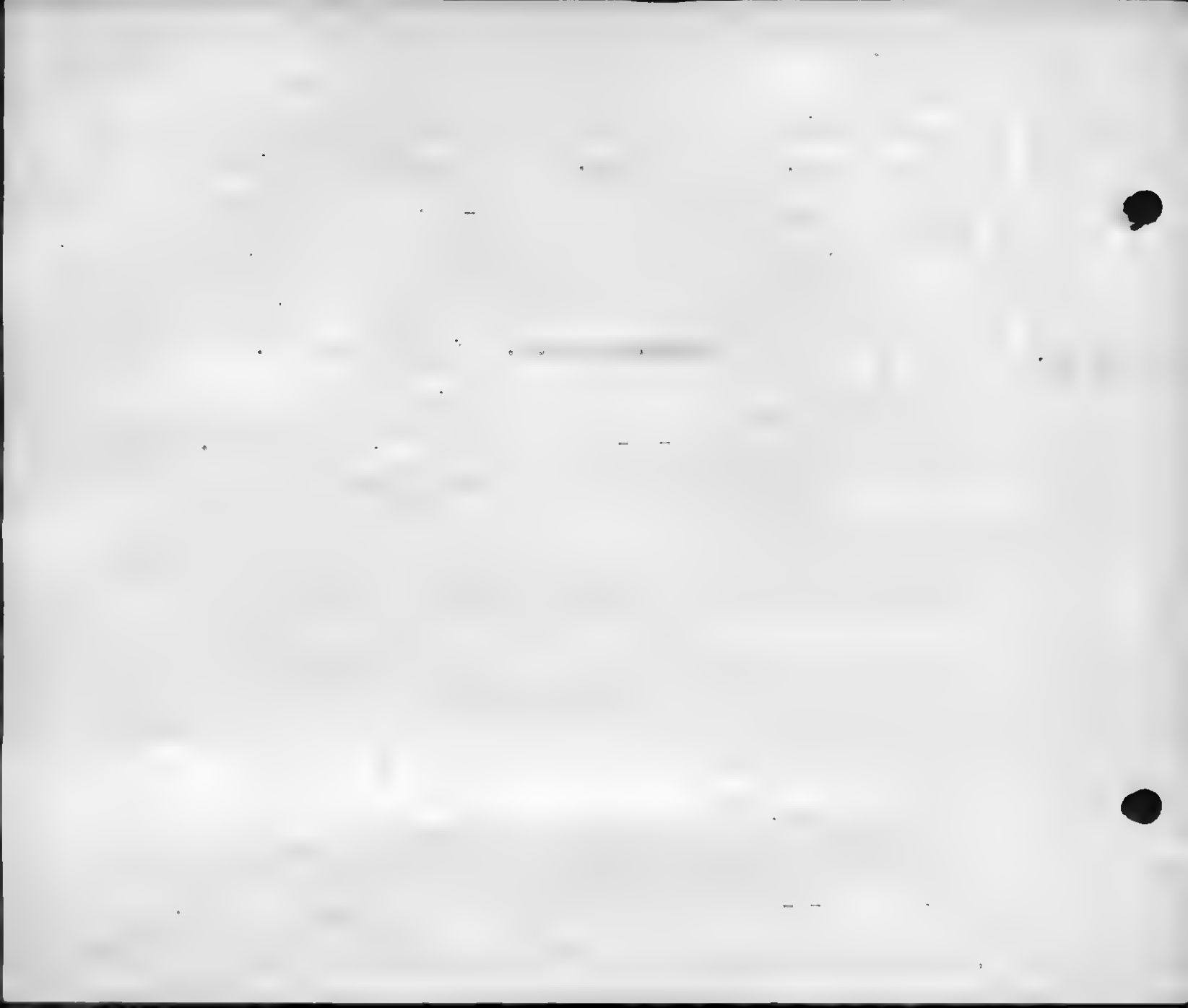
## CERTIFICATE OF DEATH

02242

12022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> c. LENGTH OF STAY IN IT <u>5yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> d. STREET ADDRESS <u>138 W. North Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Eugene</u> Middle <u>(none)</u> Last <u>Parker</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>28</u> Year <u>1966</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec 9 1912</u>		<b>9. AGE</b> (In years last birthday) <u>53</u> yrs IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Packing house</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Middletown, Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Elias Parker</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Anker</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>230-09-7094</u>	
<b>17. INFORMANT</b> <u>Charlotte Parker</u>		<b>Address</b> <u>138 W. North St</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/25</u> <b>to</b> <u>2/28</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>2/28</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>10:50 P.M.</u> <b>from the causes and on the date stated above</b>			
<b>22a. SIGNATURE</b> <u>Donald E. Martin</u>		<b>22b. DATE SIGNED</b> <u>2/28/66</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Do-nald E. Martin M.D.</u>		<b>22d. ADDRESS</b> <u>418 North Potomac St. Hagerstown, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-8-1966</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Hagerstown Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John K. Watson of Hagerstown Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 3 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>  </b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

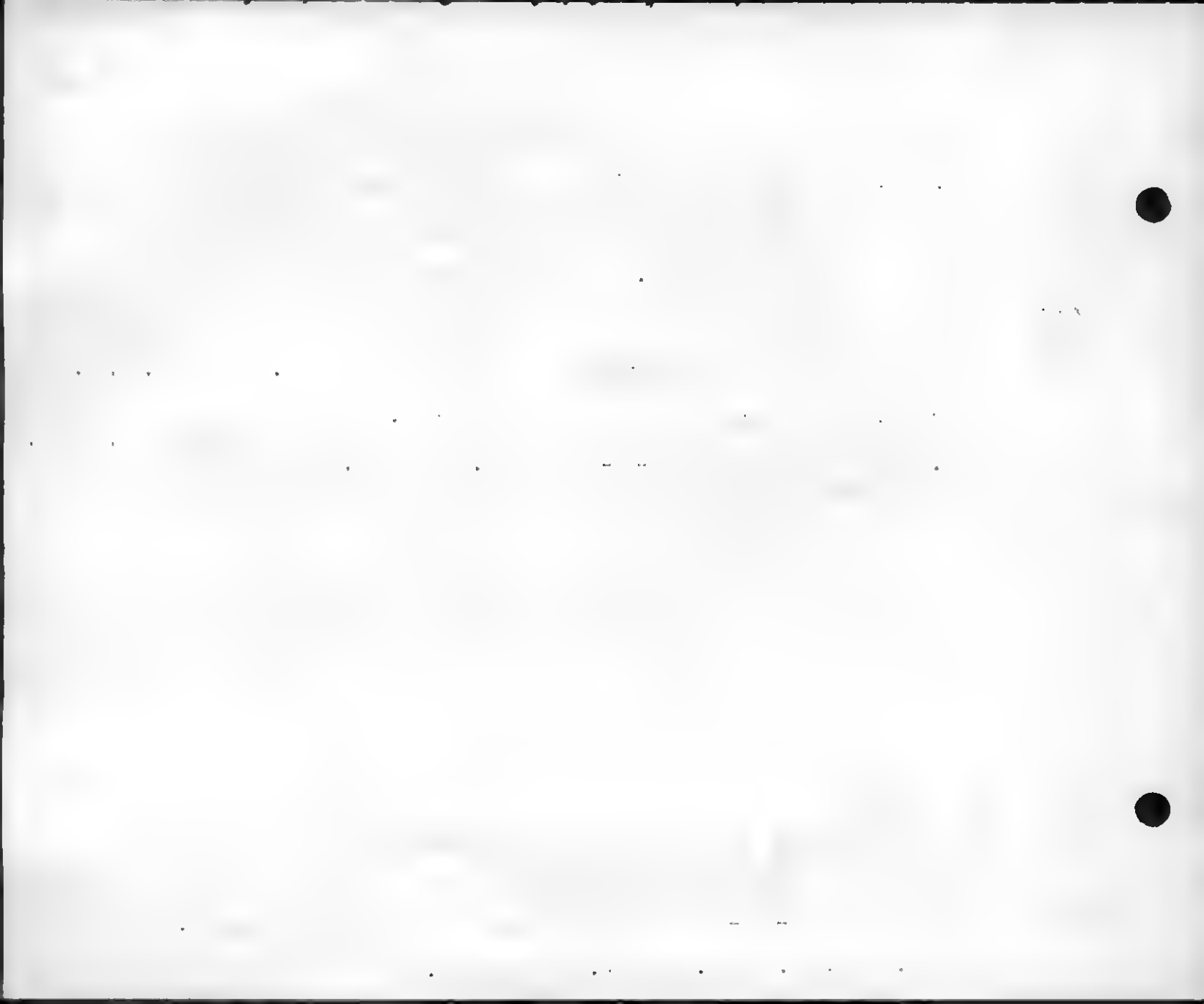
02243

02244

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rohrsersville</b> c. LENGTH OF STAY in 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rohrsersville Rfd. 1</b> d. STREET ADDRESS <b>Locust Grove</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nyle C. Poffenberger</b>		4. DATE OF DEATH Month Day Year <b>February 13, 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1910</b>
9 AGE (In years lost birthday) <b>55</b> yrs		IF UNDER 1 YEAR Months Days Hours Min. <b>6 12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Locust Grove, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harmon Poffenberger</b>		14. MOTHER'S MAIDEN NAME <b>Mary S. Poffenberger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. ce) <b>No.</b>		16. SOCIAL SECURITY NO. <b>220-09-9102</b>	
17. INFORMANT <b>Mrs. Dorothy M. Poffenberger,</b>		Address <b>Rohrsersville Rfd. 1, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>47 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-18-1961</b> , to <b>2-13-1966</b> , that (I) (we) last saw the deceased alive on <b>2-13-1966</b> , and that death occurred at <b>17:00</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>J. Secodari</b>		22b. DATE SIGNED <b>2-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDA RI</b>		22d. ADDRESS <b>BOONSBORO RD MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-15-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro Md.</b>
24. FUNERAL DIRECTOR ADDRESS <b>John H. Bast, Jr. 112 N. Main St., Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 16 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>John H. Bast, Jr.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 1 and 2 to the funeral director, within 72 hours after death.

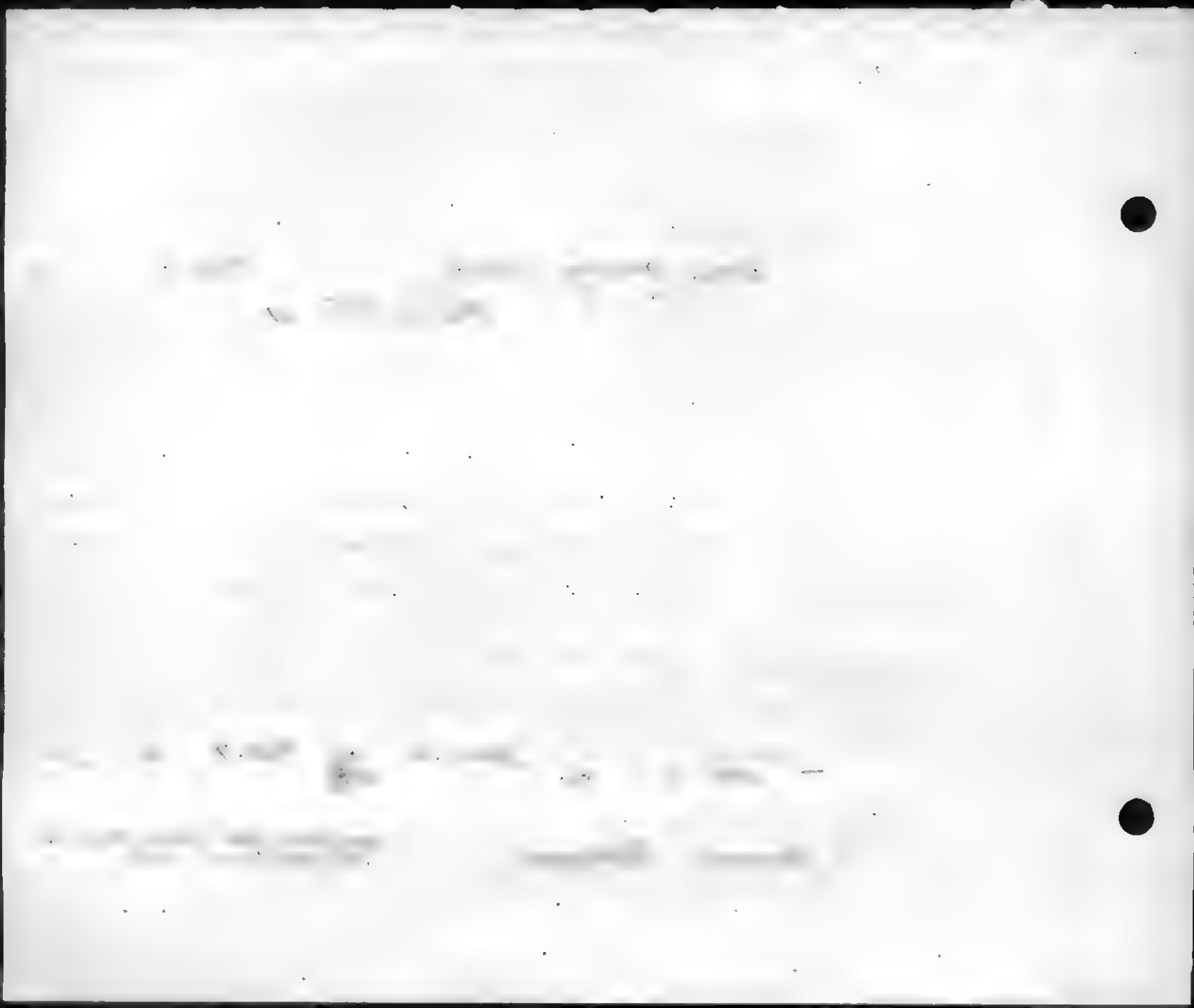


TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Md State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b> d. STREET ADDRESS <b>4803 M street.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Inez</b> Middle <b>Mary</b> Last <b>Pride</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 7, 1915</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>578 26 1978</b>	
17. INFORMANT <b>Earl C Pride</b>		Address <b>Hillside Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b> DUE TO (b) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO (c) <b>RETROPERITONEAL CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 13, 1966</b> to <b>FEB. 7, 1966</b> , that (I) (we) last saw the deceased alive on <b>FEB. 7, 1966</b> , and that death occurred at <b>2:18 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Antonio H. Pallagrosi</b>		22b. DATE SIGNED <b>2-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO Pallagrosi</b>		22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb 10, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington D. C.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>553 11 1966</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



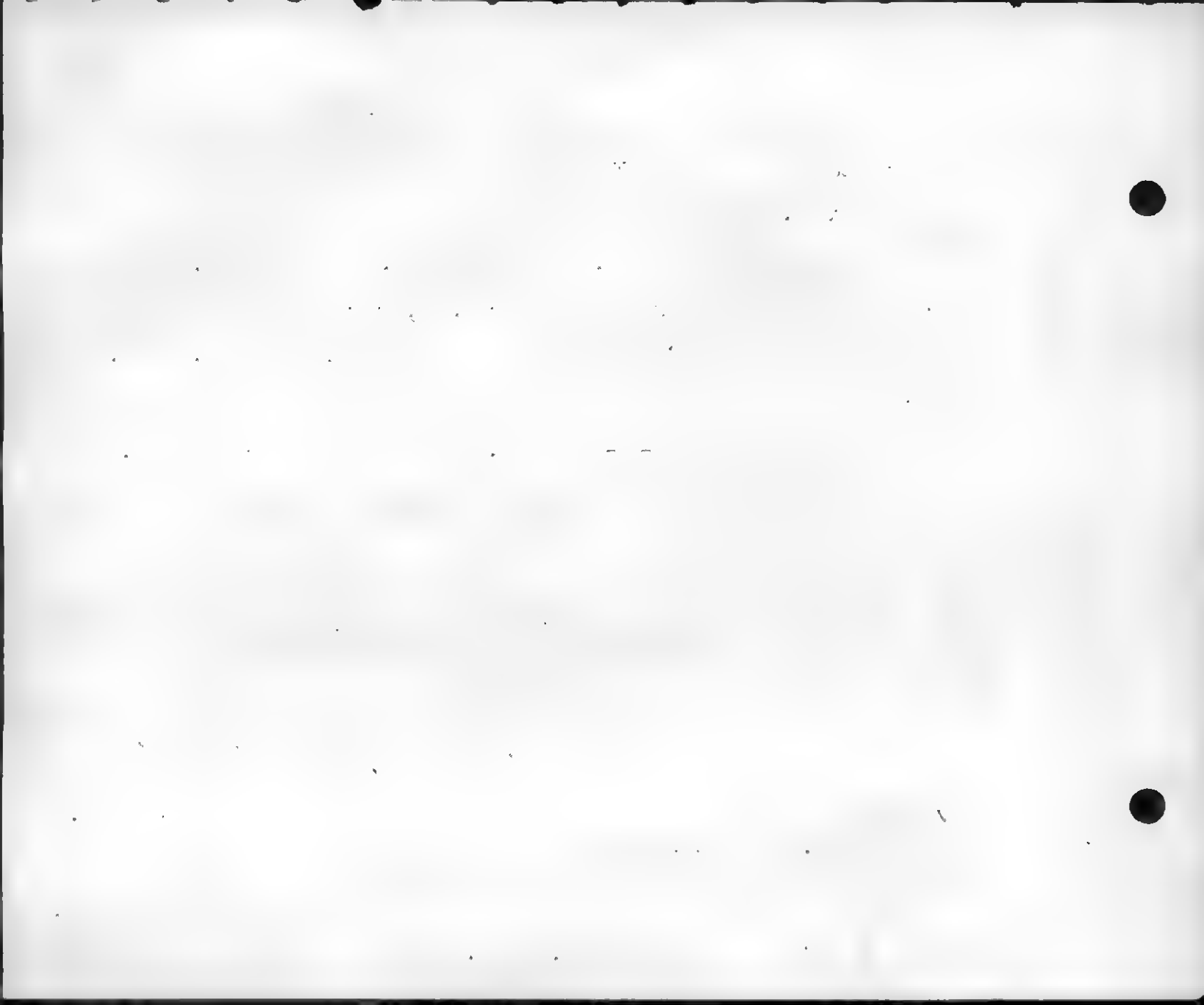


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02945 CERTIFICATE OF DEATH 02926											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4wks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Highfield					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital						d. STREET ADDRESS Box 45				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence W. Pryor Sr.						4. DATE OF DEATH Month Day Year Feb. 24 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1897		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker				10b. KIND OF BUSINESS OR INDUSTRY Military Reservation		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Pryor						14. MOTHER'S MAIDEN NAME Amanda Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 219-12-0773		17. INFORMANT Mrs. Anna Prichard				Address Highfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) ( <i>this hospital</i> ) attended the deceased from <i>1-29-</i> 19 <i>66</i> , to <i>2-24-</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2-24-</i> 19 <i>66</i> , and that death occurred at <i>11A</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Dalton M. Welty</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>2-24-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>DALTON M. WELTY</i>						22d. ADDRESS <i>Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/27/66		23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City, town or county) (State) Lantz, Frederick Co., Md.			
24. FUNERAL DIRECTOR <i>Walter J. Gore</i>						25a. REC'D BY REGISTRAR Waynesboro, Penna.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

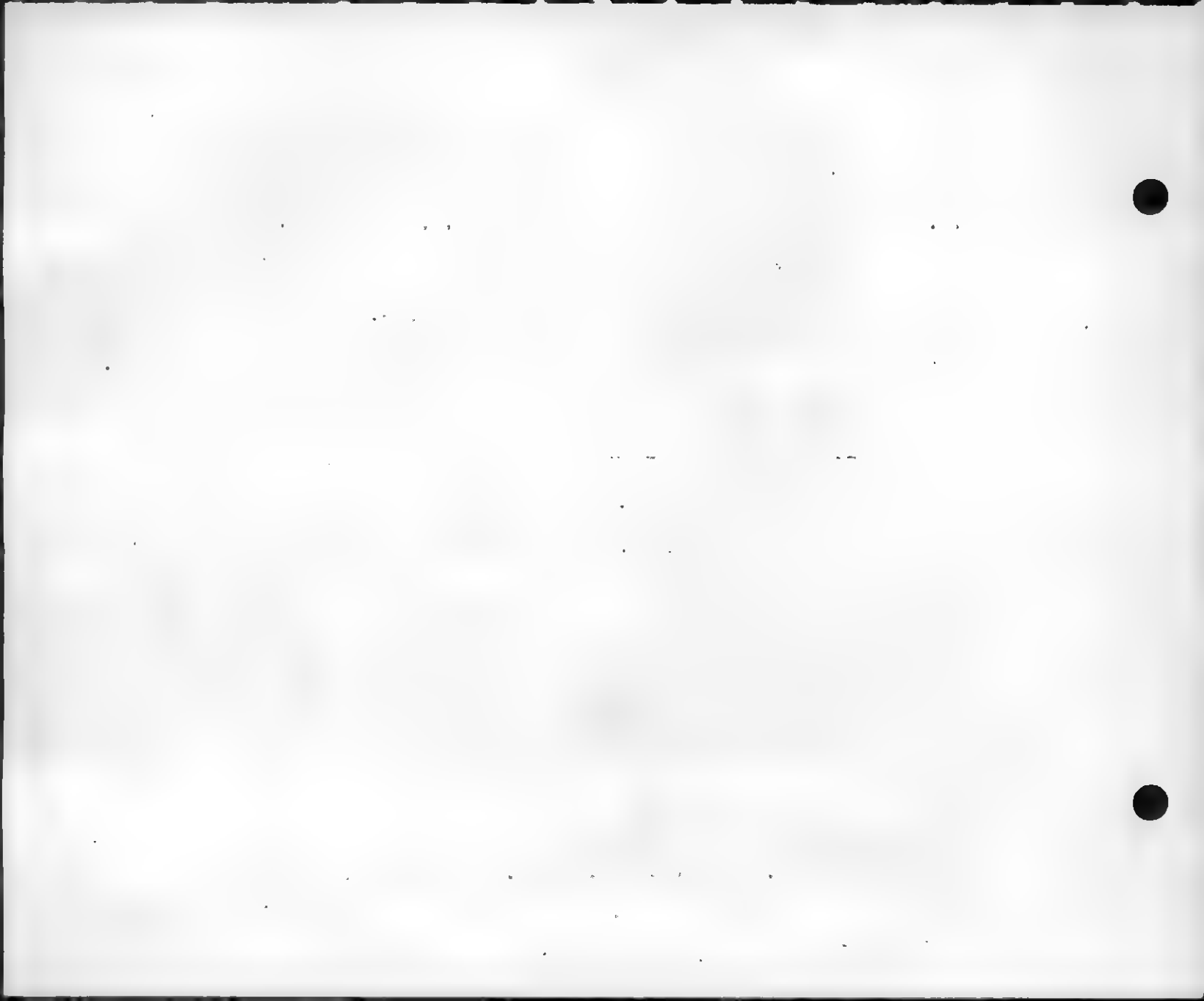


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL SHARPSBURG</b> c. LENGTH OF STAY IN 1b <b>82 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D.# 3 SHARPSBURG</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL SHARPSBURG</b> d. STREET ADDRESS <b>R.D.# 3 SHARPSBURG</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>DAISY MARIE REEL</b>			4. DATE OF DEATH <b>FEBRUARY 26 19 66</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 29, 1883</b>		9. AGE (In years last birthday) <b>82 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS REEL</b>					14. MOTHER'S MAIDEN NAME <b>MARY GRICE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>216-38-0787</b>		17. INFORMANT <b>SHERIDAN REEL R.D.# 3 SHARPSBURG, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>Recent</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Edward W. Ditto</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>2/28/1966</b>	
EXAMINER'S NAME (Type) <b>EDWARD W. DITTO MR. M.D. 215 W. WASHINGTON ST. HAGERSTOWN, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 1, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>Carlson Rouse</b>				ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

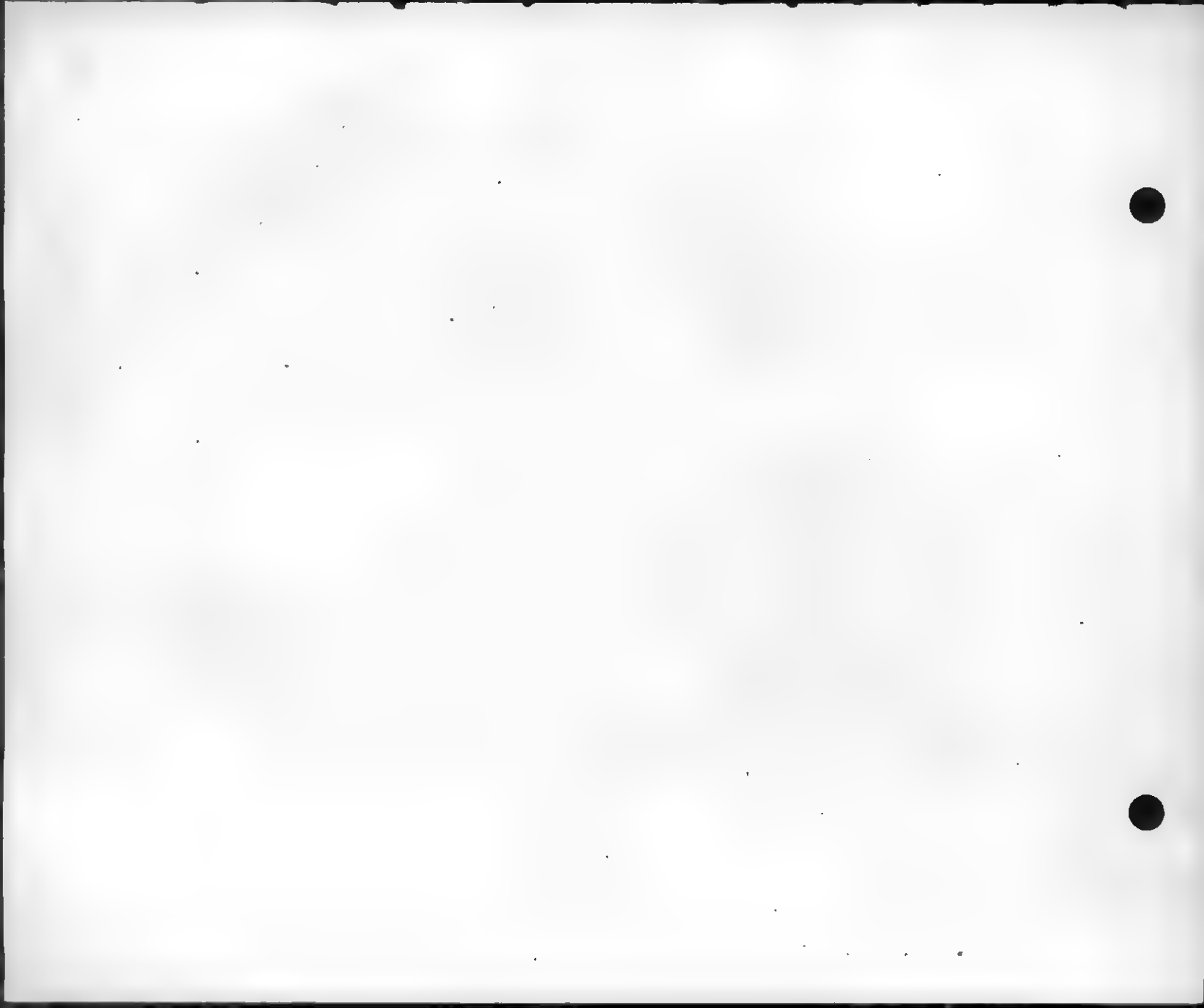


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. LENGTH OF STAY IN ID <u>Lifetime</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>53 Elizabeth St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>W.</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-35</u>
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>17</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John W. W.</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Dorothy Kessinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Dorothy Kessinger</u> Address <u>Bar</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> 7730 DUE TO <u>gastro-intestinal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <u>Dehydration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2 days</u> <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-</u> , 19 <u>66</u> , to <u>2-1-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-1-</u> , 19 <u>66</u> , and that death occurred at <u>2-1-</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Secondary</u>		22b. DATE SIGNED <u>2-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARY</u>		22d. ADDRESS <u>BOONS BORO</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE		FEB 7 1966	



## CERTIFICATE OF DEATH

Reg. Dist. No.

02929

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Pleasant Valley Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Pleasant Valley			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION residence				d. STREET ADDRESS 270 #2, Knoxville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE DEWEY RICKARDS, Sr.				4. DATE OF DEATH Month Day Year February 17, 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 15, 1900	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Garrett's Mill, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Francis Marion Rickards				14. MOTHER'S MAIDEN NAME Annie Belle Ohler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 705-00-7 39	17. INFORMANT Mrs. Leoda J. Rickards 270 #2, Knoxville, Md. 21752				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ECORONARY occlusion</u> DUE TO <u>SEVERE CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2-5 yrs.</u> (c) <u>2-5 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2-5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-15-1966</u> to <u>2-17-1966</u> , that I last saw the deceased alive on <u>2-17-1966</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Brownsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. E. Mitt</u>				DATE SIGNED <u>2-19-66</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/20/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brownsville Hts. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brownsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1 after death: Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

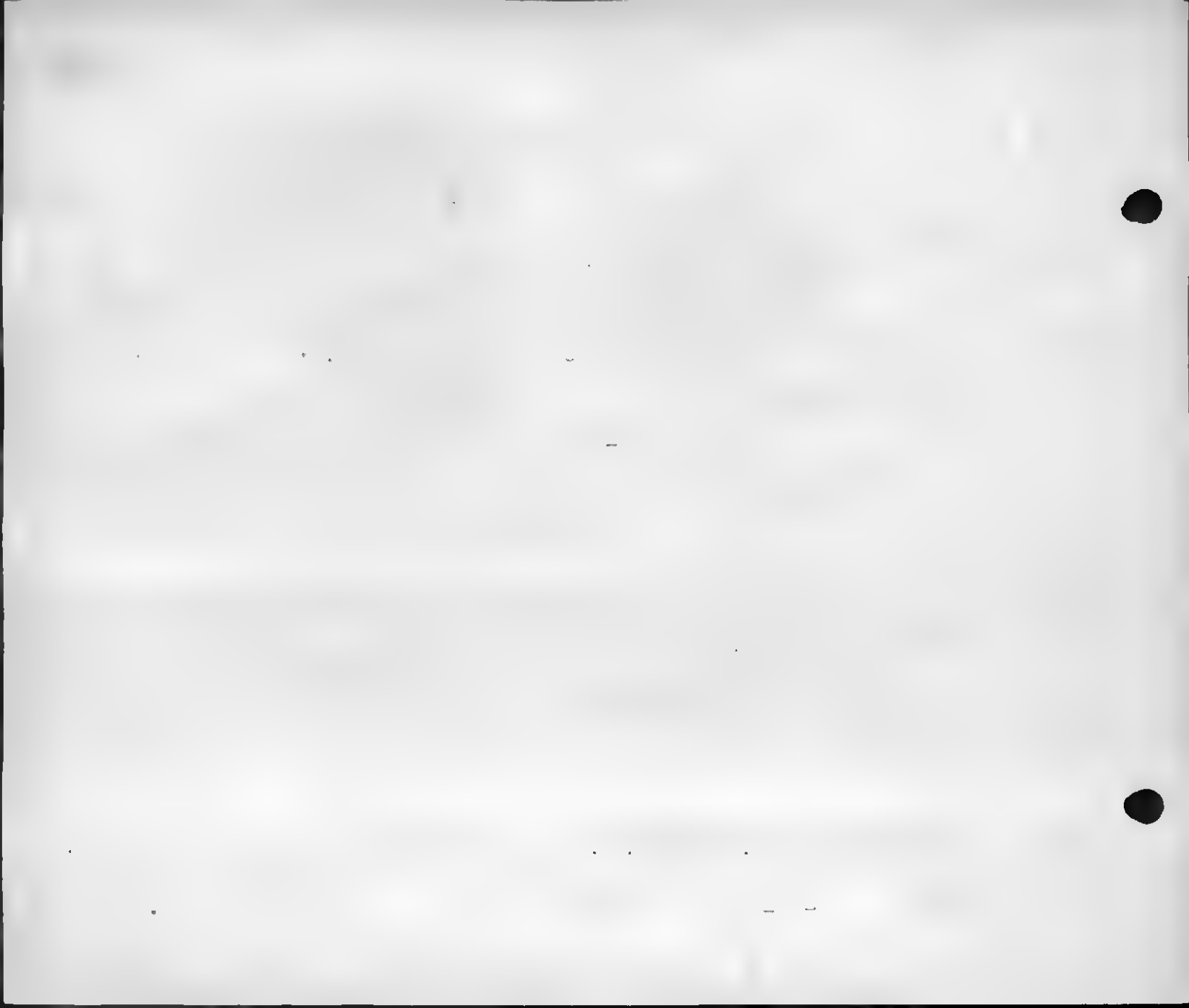
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

22843

02930

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b> c. LENGTH OF STAY IN 1b <b>33yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b> d. STREET ADDRESS <b>675 Pennsylvania Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>William McKinley Russ</b>		<b>4. DATE OF DEATH</b> Last First Middle <b>Feb 9 1966</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Jan 8 1902</b>		<b>9. AGE</b> (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Army Depot</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Middleway W. Va.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>	
<b>13. FATHER'S NAME</b> <b>Warner McKinley</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Isabella Darline</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>220-10-3877</b> <b>17. INFORMANT</b> <b>William Russ</b> <b>Address</b> <b>663 Pennsylvania Ave</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Cardiac Failure</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>4-10</b> DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 weeks</b> <b>3 1/2 years</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Multiple Pulmonary Emboli</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)															
<b>21. I certify that (I) (this hospital) attended the deceased from 2-7-1966 to 2-9-1966 that (I) (we) last saw the deceased alive on 2-7-1966, and that death occurred at 5:30 P.M. from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dalton L. Selty, M.D.</b>												<b>22b. DATE SIGNED</b> <b>2-11-66</b>			
<b>22d. ADDRESS</b> <b>998 Potomac Avenue, Hagerstown, Md.</b>															
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>2-12-1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>				<b>23d. LOCATION (City, town or county)</b> (State) <b>Hagerstown, Md.</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John R. Watson Jr. Hagerstown Md</b>												<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 14 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Malcolm Judge</b>	



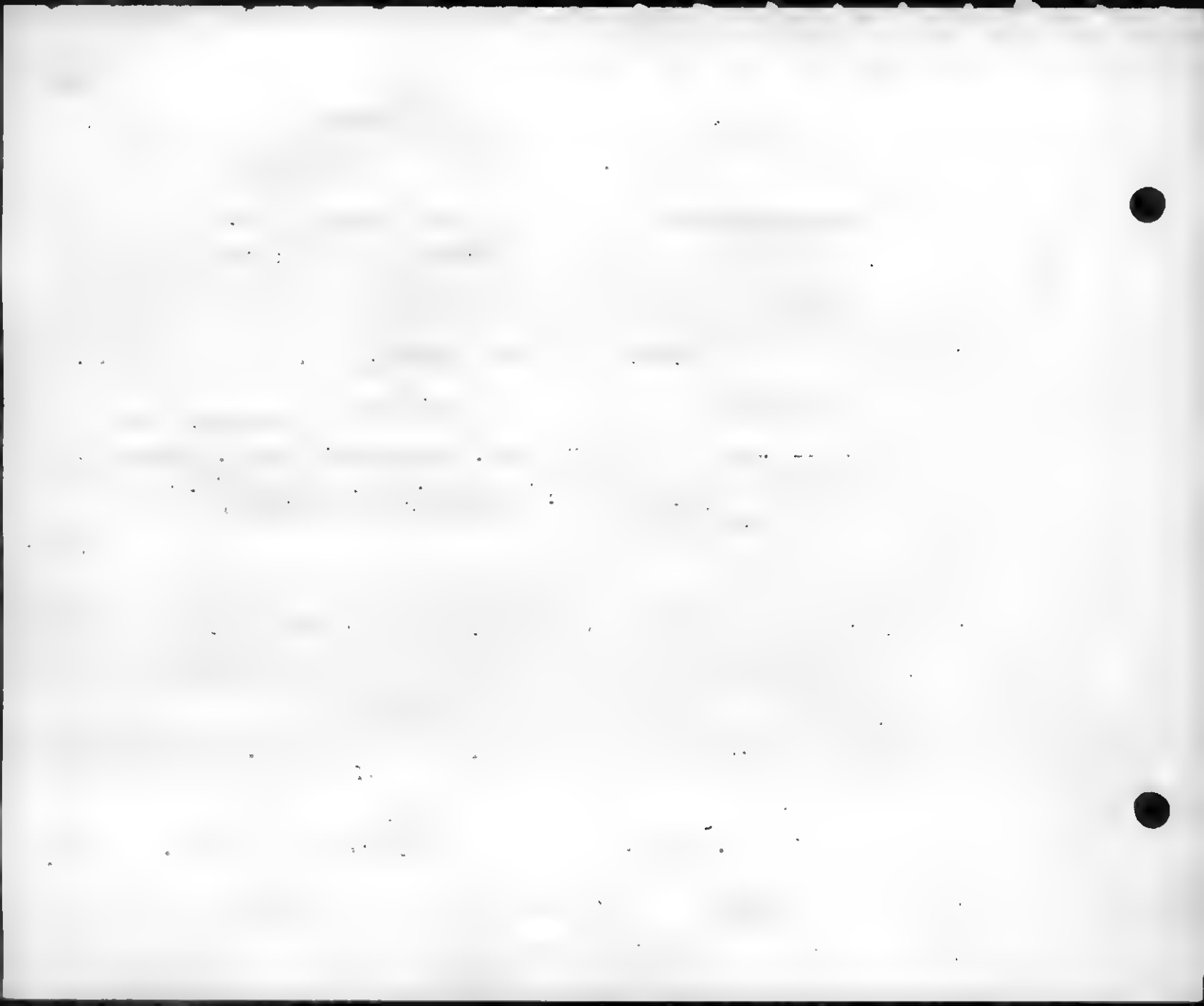
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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 HRS.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>322 N. CANNON AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Russell</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1966</b>		5. FUNDER 1 YEAR IF FUNDER 24 HRS. Months <b>19</b> Days <b>66</b> Hours <b>13</b> Min. <b>certain</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>NOV. 28, 1908</b>		9. AGE (In years last birthday) <b>57</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COUNTY COURT HOUSE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MD.</b>	
13. FATHER'S NAME <b>JOHN RUSSELL</b>		14. MOTHER'S MAIDEN NAME <b>MARY ALBERT</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>705-10-8587</b>		17. INFORMANT <b>MRS. HELEN RUSSELL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured aneurysm, abdominal aorta below bifurcation of renal arteries with dissection of the arterial coats</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>451X</b> (c) <b>DUE TO</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive and atherosclerotic heart disease</b>		4 years certain		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from <b>Feb. 23, 1966</b> to <b>Feb. 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 23, 1966</b> , and that death occurred at <b>11:20 A</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>William T. Layman</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		22d. ADDRESS <b>100 Professional Arts Bldg., Hagerstown, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/26/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN CEMETERY</b>	
23d. LOCATION (City, town or county) (State) <b>WASHINGTON CO., MARYLAND</b>		24. FUNERAL DIRECTOR <b>Charles M. Rouse</b>		25a. REC'D BY REGISTRAR <b>Wm. Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Wm. Charles Judge</b>		25c. DATE <b>MAR 1 1966</b>		25d. HAGERSTOWN, MARYLAND	



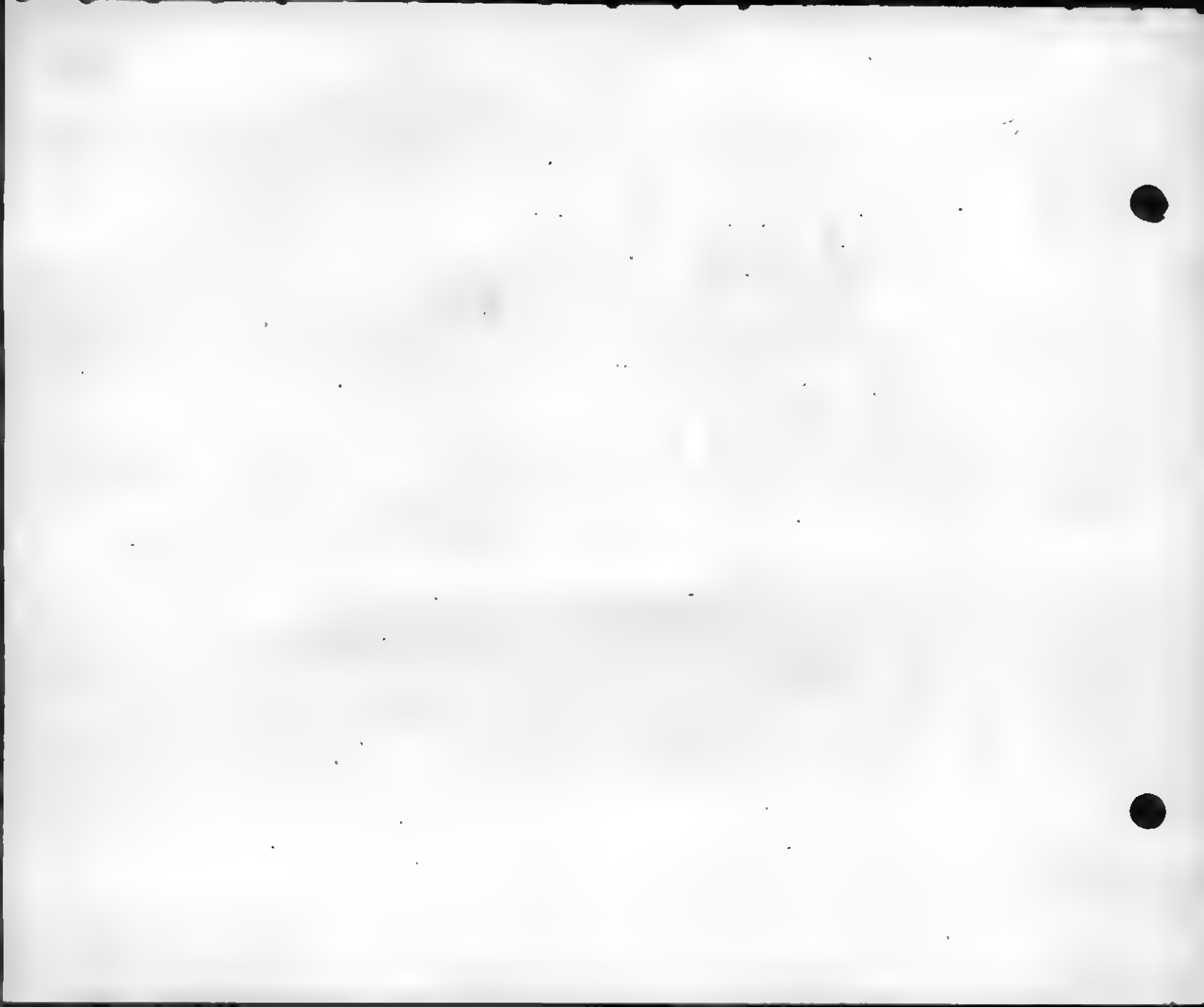
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Fredricks</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>4 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Friendship Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Jefferson</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Charles Town</u> d. STREET ADDRESS <u>600 Brook St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GERARDO PAUL SALSAVO</u> First Middle Last 4. DATE OF DEATH <u>Feb 27 1966</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>Oct 13, 1901</u> 9. AGE (In years last birthday) <u>64</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Cab-operator</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unk.</u> 14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>217039514</u> 17. INFORMANT <u>Mrs. Louella Salzano Charles Town</u> Address <u>W. Va.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Diffuse Bi-Lateral Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebral Syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 20</u> , 19 <u>66</u> , to <u>Feb 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 27</u> , 19 <u>66</u> , and that death occurred at <u>11:40</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J.H. Beasley</u> 22c. PHYSICIAN'S NAME (Type) <u>J.H. Beasley</u>		22b. DATE SIGNED <u>Feb 27/66</u> 22d. ADDRESS <u>Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town or county) (State) <u>Queen City</u>	
24. FUNERAL DIRECTOR <u>E. Guy Dwyer C. Town</u> ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

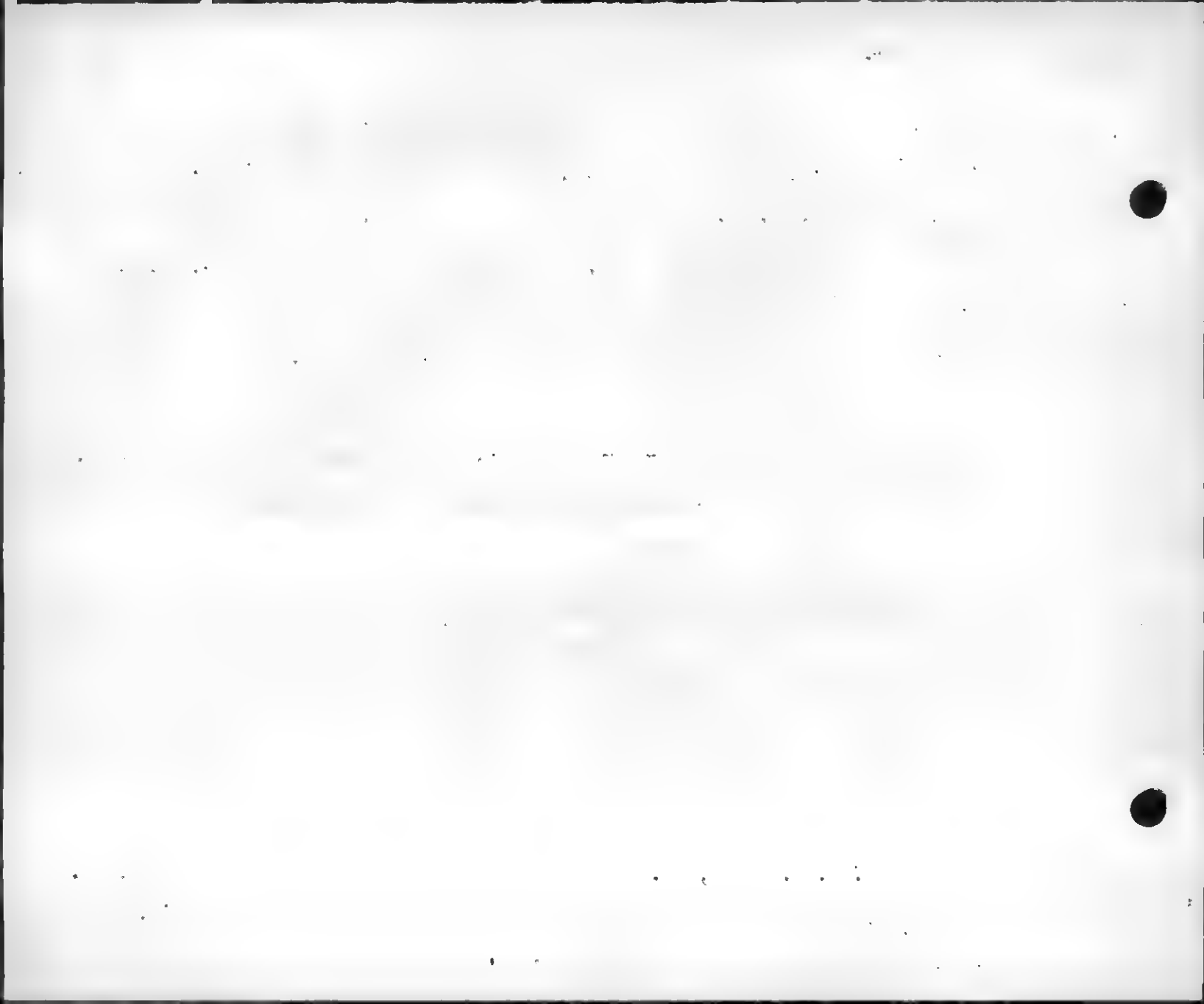


1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clearspring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mercersburg, Pa.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clearspring, Md., R. #1		d. STREET ADDRESS S. Park Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM T. SCHAEFFER		4. DATE OF DEATH Month Day Year Feb. 21, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/1875
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gen. work	
11. BIRTHPLACE (State or foreign country) Mercersburg, Pa., R.D.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Schaeffer		14. MOTHER'S MAIDEN NAME Julia Parrot	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-03-3355	
17. INFORMANT Mrs. James Scott		Address Mercersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 4261 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		22. DATE SIGNED 2-22-66	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/25/66	23c. NAME OF CEMETERY OR CREMATORY Fairview	23d. LOCATION (City, town or county) (State) Mercersburg, Pa.
24. FUNERAL DIRECTOR J. H. Sinner		25a. REC'D BY REGISTRAR FEB 28 1966	
ADDRESS Mercersburg, Pa.		25b. REGISTRAR'S SIGNATURE W. H. Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

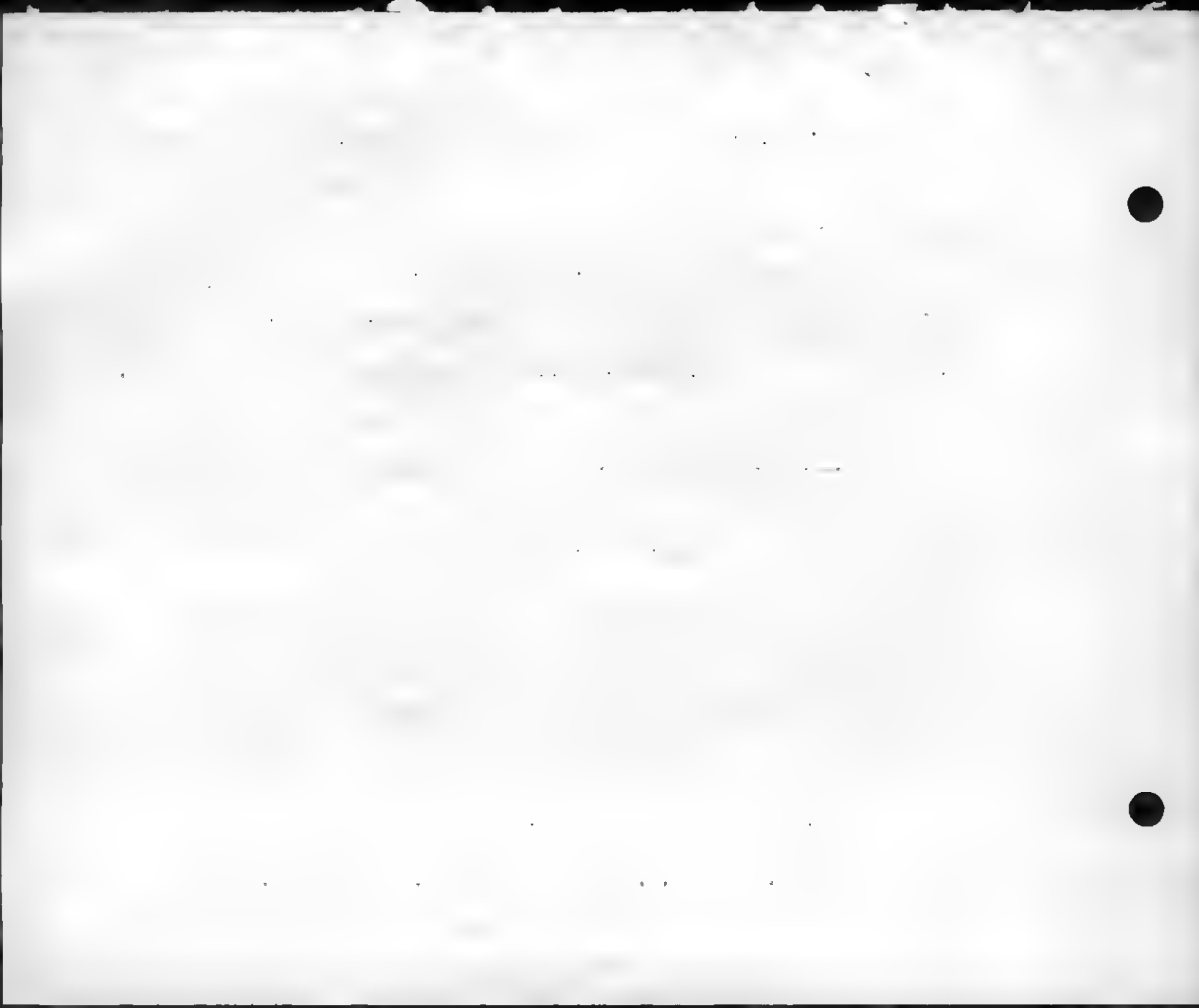
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
c. LENGTH OF STAY IN 1b <b>10 MINUTES</b>		d. STREET ADDRESS <b>823 PINE STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD TRONE SCHINDEL</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 2 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 12, 1915</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DETECTIVE BUREAU</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD SCHINDEL</b>		14. MOTHER'S MAIDEN NAME <b>RUTH TRONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-2307</b>	
17. INFORMANT <b>MRS. PHYLLIS SCHINDEL</b>		<b>823 PINE STREET</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Howard N. Weeks</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>HOWARD N. WEEKS M.D.</b>		<b>580 NORTHERN AVE., HAGERSTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>FUNKSTOWN, CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>FUNKSTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Charles H. Rouse</i>		25a. REC'D BY REGISTRAR DATE <b>2/2/66</b>	
25b. REGISTRAR'S SIGNATURE <i>John</i>		25c. DATE SIGNED <b>2/2/66</b>	

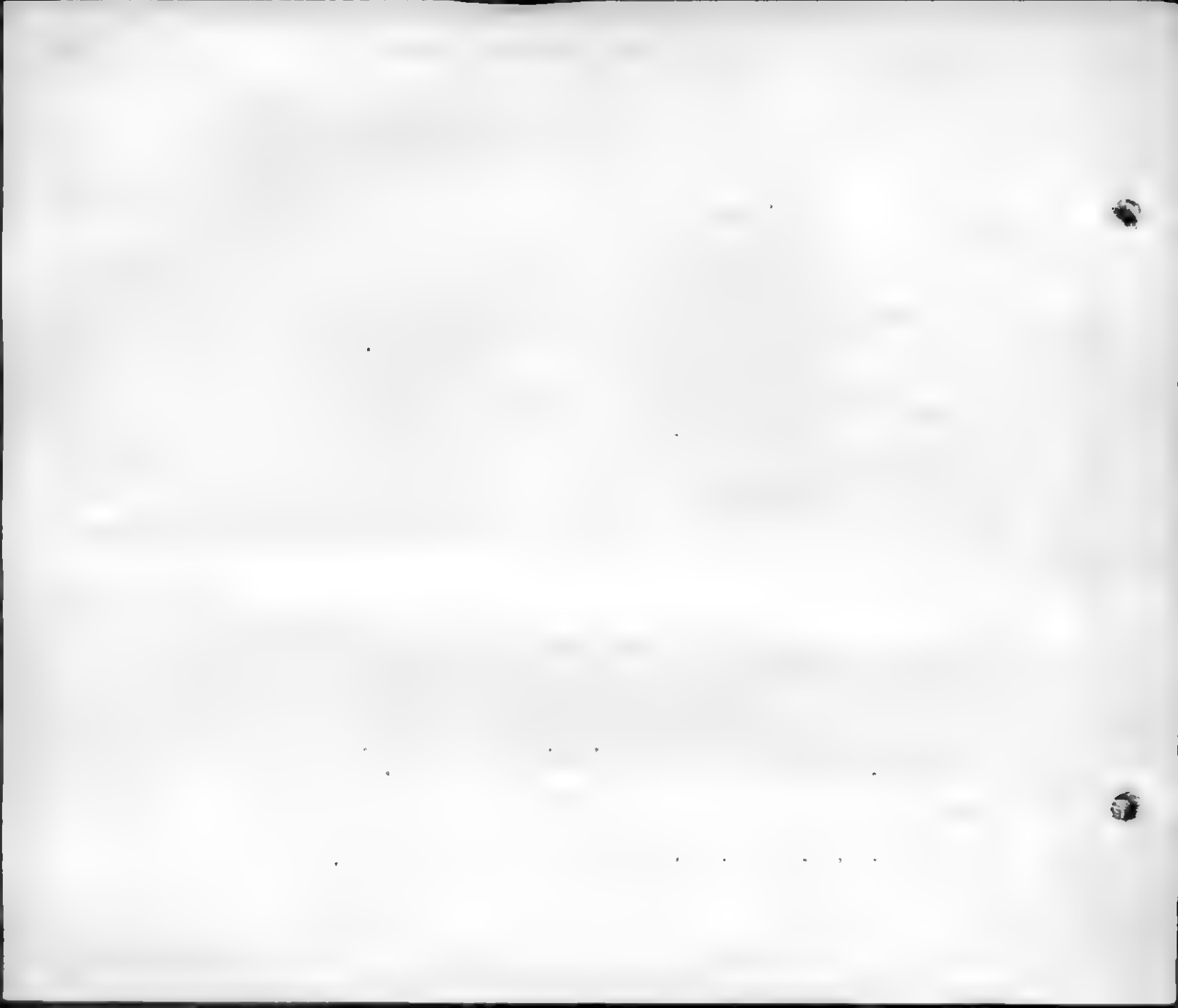


CERTIFICATE OF DEATH

Reg. Dist. No.

112835

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Pa.</u> b COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mercersburg,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shick Conv. Home</u>				d. STREET ADDRESS <u>61 Linden Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>WILLIAM</u> Last <u>SECRIST</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/18</u> 2	9. AGE (In years last birthday) <u>43</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barotaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Comotery</u>		11. BIRTHPLACE (State or foreign country) <u>Sylvan, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Secrist</u>				14. MOTHER'S MAIDEN NAME <u>Susan Zimmerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>196-14-4052</u>		17. INFORMANT Address <u>Mrs. Harry Sites Hagerstown, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Jan. 28,</u> 19 <u>66</u> , to <u>Feb. 15,</u> 19 <u>66</u> , that I last saw the deceased alive on <u>Feb. 14,</u> 19 <u>66</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>215 W. Washington St., Hagerstown, Md.</u> DATE SIGNED <u>2-16-66</u>							
ACTUAL SIGNATURE <u>H. W. Ditto, Jr.</u>		M.D. <u>215 W. Washington St., Hagerstown, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		<u>Hagerstown, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/1/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town or county) (State) <u>Mercersburg, Pa. (Franklin)</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Allen Lanning</u>		ADDRESS <u>Mercersburg, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 21 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

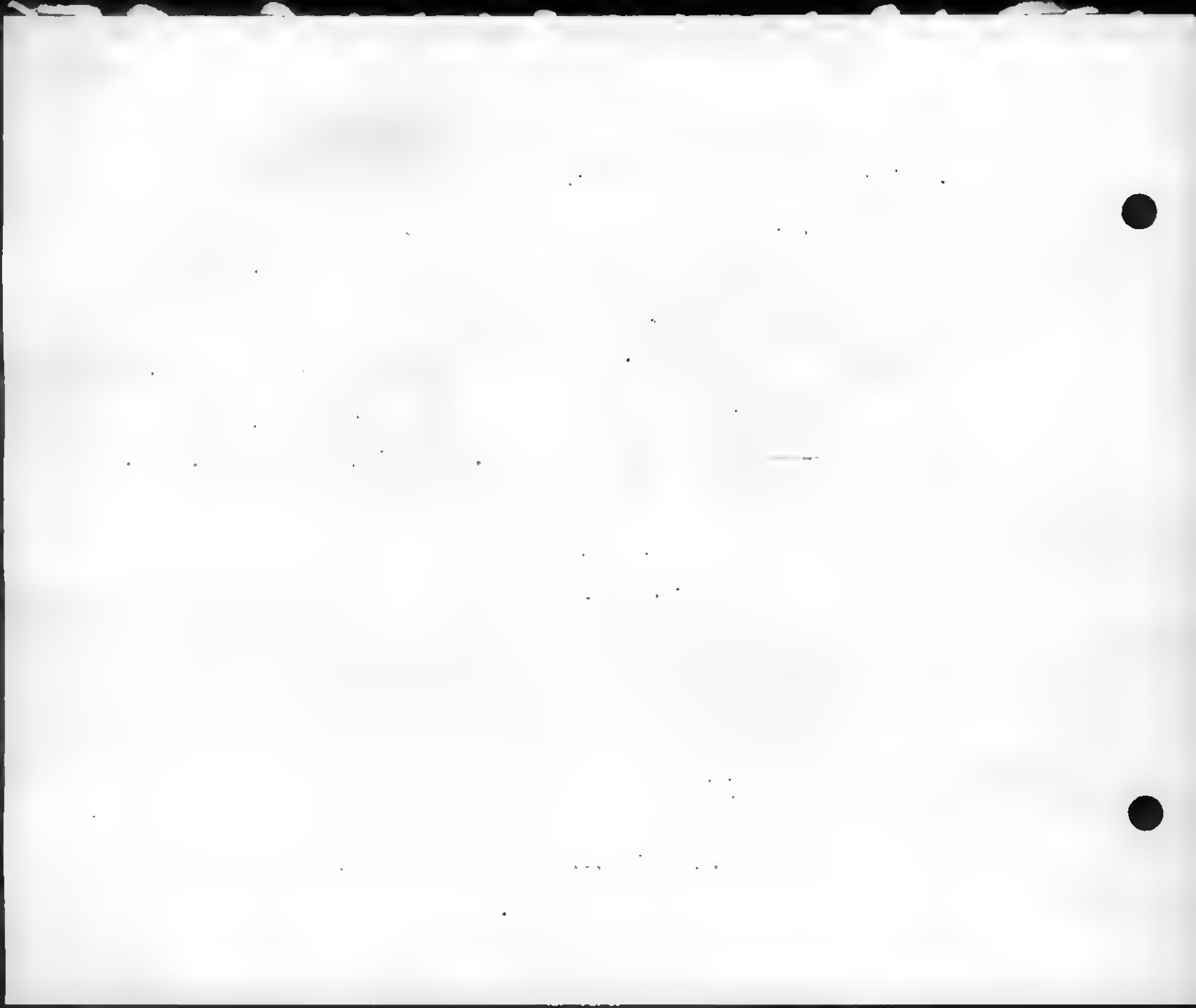
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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02936

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CONOCOCHEAQUE</b> c. LENGTH OF STAY IN 1b <b>3 MOS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GATEWAY CONV. HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>526 W. CHURCH STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>JANE</b> Last <b>SHANK</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>24</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 4, 1883</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR: Months <b>2</b> Days <b>1</b> Hours <b>1</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MD.</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>JOHN SOCKS</b>		15. MOTHER'S MAIDEN NAME <b>SARAH YOUNG</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		17. SOCIAL SECURITY NO. <b>NONE</b>	
18. INFORMANT <b>MRS. LELIA SHANHOLTZ</b>		19. ADDRESS <b>526 W. CHURCH ST. HAGERSTOWN, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>ARTERIOSCLEROSIS, GENERALIZED</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9 Dec.</b> , 19 <b>65</b> , to <b>24 Feb.</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>24 Feb.</b> , 19 <b>66</b> , and that death occurred at <b>9:44</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>2/25/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM N. FENDER M.D.</b>		22d. ADDRESS <b>218 N. POTOMAC ST. HAGERSTOWN, MARYL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/28/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Charles M. Rouse</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>MAR 1 1966</b>	



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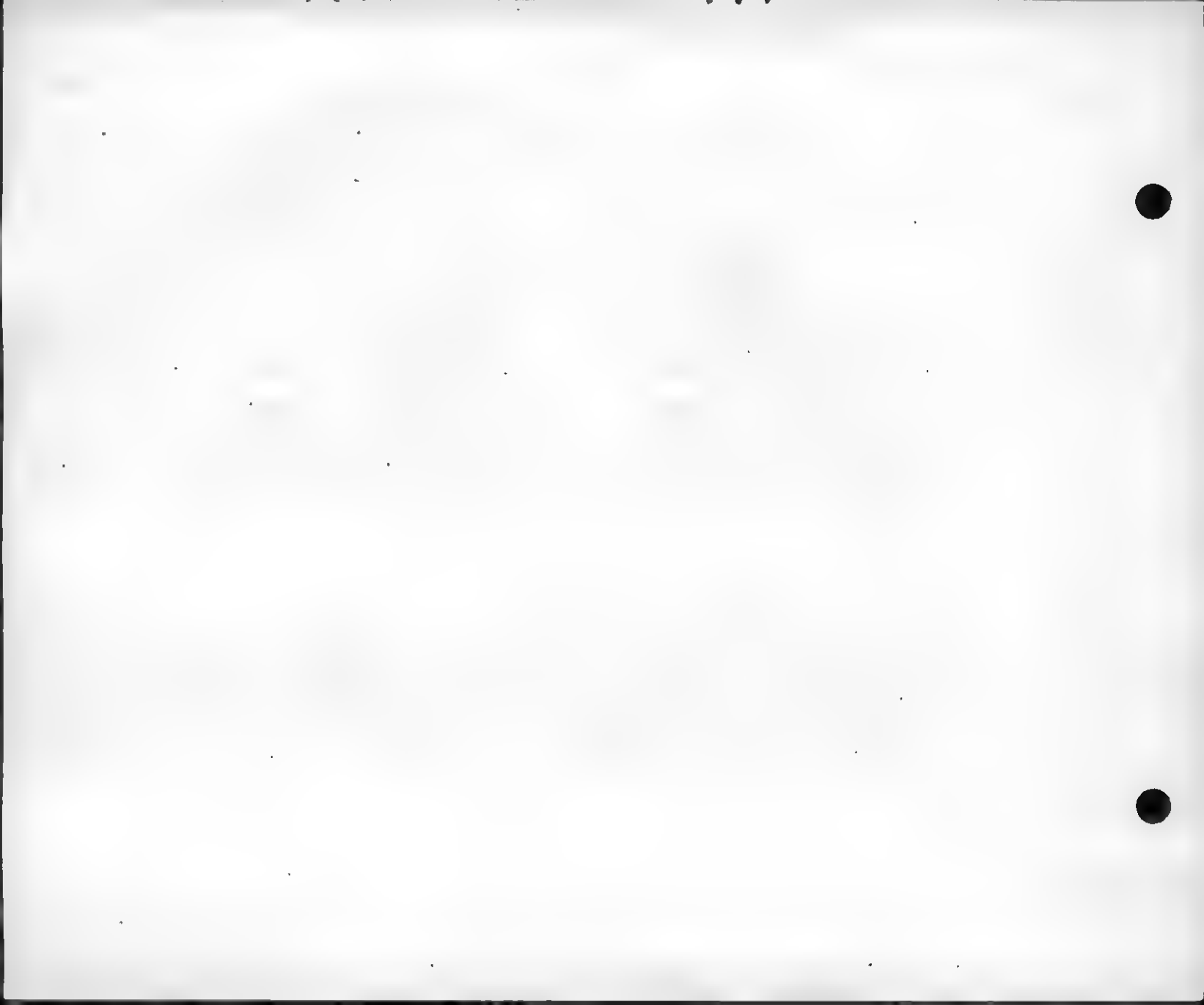
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02956

02387

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN <b>55</b> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>120 Clearview Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THELMA</b> Middle <b>MADILENE</b> Last <b>SHANK</b>				4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 66</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1910</b>		9. AGE (In years last birthday) <b>55</b> yrs.	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min.	11. IF UNDER 24 HRS Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lutheran church</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Huyetts Crossroad, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frisby Spickler</b>				14. MOTHER'S MAIDEN NAME <b>Edythe Mong</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>212-14-7717</b>		17. INFORMANT <b>Robert H. Shank, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Carcinoma of Rt. Breast</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1964</b> , to <b>Feb 19, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 9</b> 1966, and that death occurred at <b>12 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Lloyd A. Hoffman</b> M.D.				22b. DATE SIGNED <b>2/21/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-22-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





VR A15 (4)  
20M 5-63

## 02935

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Garlock Convalescent Hospital</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Tenley</u> Last <u>Shives</u>		d. STREET ADDRESS <u>23 South Carlisle St.</u>	
5. SEX <u>Female</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1966</u>	
6. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH Month <u>February</u> Day <u>13</u> Year <u>1879</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
13. FATHER'S NAME <u>David Tenley</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Penna.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY NO. <u>209-36-4742</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Bally</u>	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> DUE TO (b) <u>Arterio-Sclerotic Heart Disease</u> DUE TO (c) <u>20 yrs</u>		17. INFORMANT Address <u>Garlock Convalescent Hospital, Hagerstown, Md</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22b. DATE SIGNED <u>Feb 16 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>P. F. WEBSTER</u>	
22d. ADDRESS <u>Greencastle, Pa</u>		22e. REC'D BY REGISTRAR <u>Charles Judge</u>	
23a. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23c. LOCATION (City, town or county) (State) <u>Mercersburg, Franklin Co., Pa.</u>		23d. DATE THEREOF <u>12/20/1966</u>	
23e. REMOVAL (Specify) <u>Burial</u>		23f. DATE OF DEATH <u>Feb 16 1966</u>	

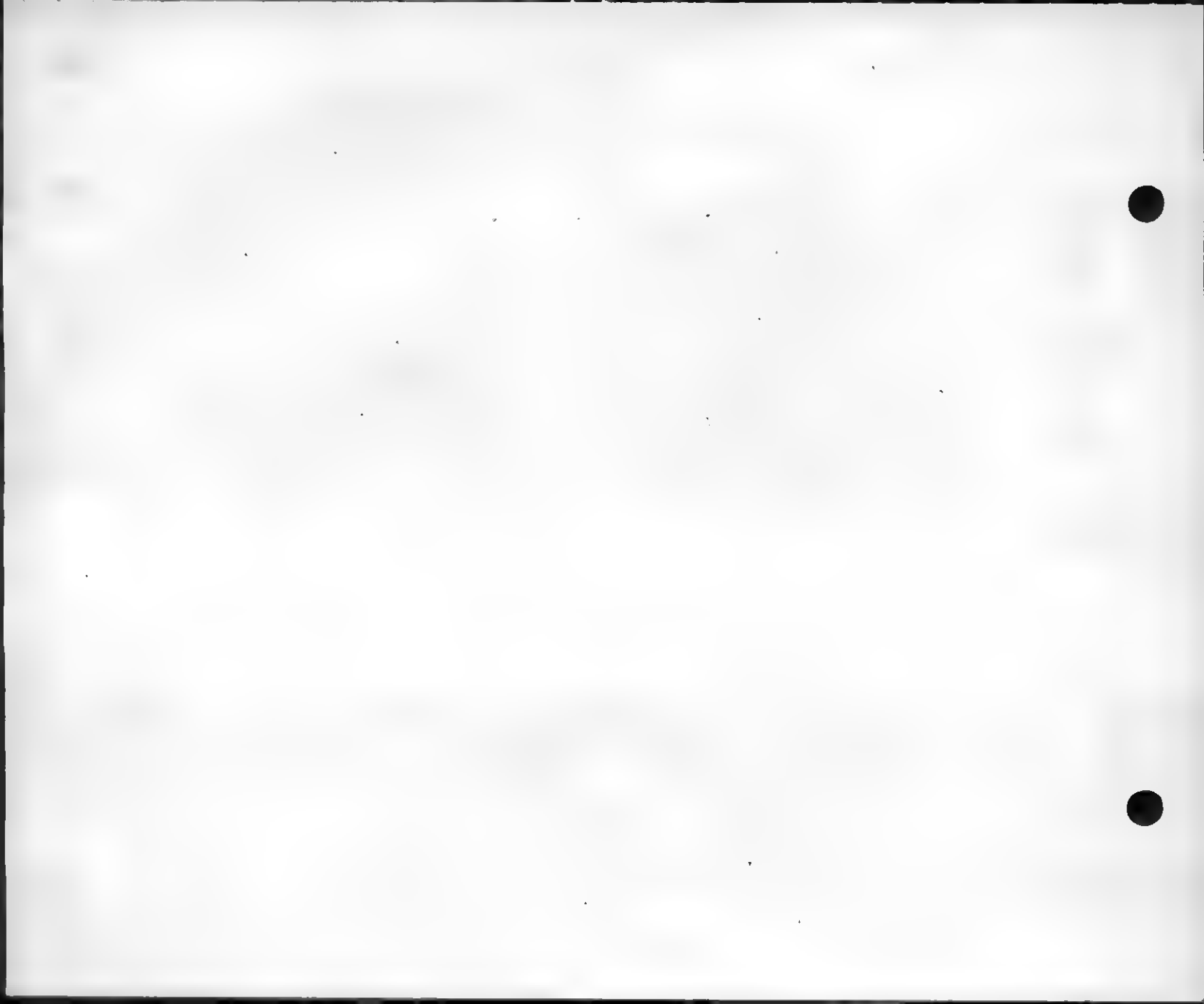


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Item 18 Film G374 2/MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>—</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASH. CO. HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASH.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN 21-1</b> d. STREET ADDRESS <b>601 BRIGHTON PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH R. SOUDERS</b>		4. DATE OF DEATH <b>FEB. 18 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/25/1920</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dress East Shoe Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOE MANUF.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN Co., PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALVIN LONG</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA ROBINSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>162-22-3118</b>	
17. INFORMANT <b>Paul E. Souders</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA &amp; PLEURAL EFFUSION</b> <b>0534</b> DUE TO <b>SEPTICEMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Operative</b> DUE TO <b>WOUND RECESS OF ABDOMEN</b> (c) <b>wound</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>7</b> <b>6-7 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS - CHRONIC PRECOMING</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>—</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11 Sept.</b> 19 <b>62</b> , to <b>18 Feb.</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>18 Feb.</b> 19 <b>66</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>19 Feb 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. N. FENDER</b>		22d. ADDRESS <b>218 N. Potomac St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>2/21/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Welsh Run Brethren Cem - Welsh Run, Pa.</b>	23d. LOCATION (City, town or county) (State) <b>Pa.</b>
24. FUNERAL DIRECTOR <b>A. E. Minnich - GREENCASTLE, Pa.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

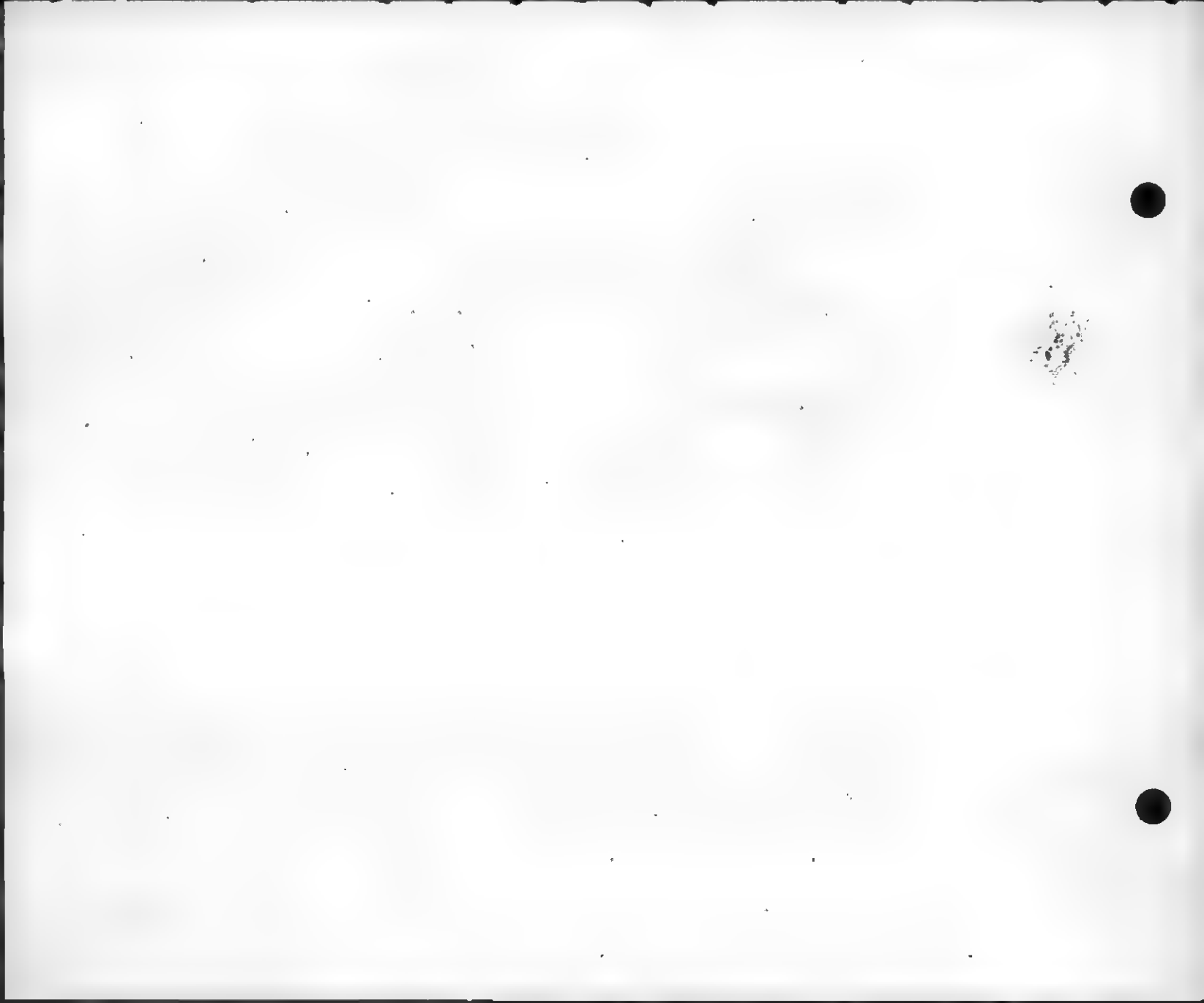


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<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <b>WASHINGTON</b> <b>MARYLAND</b> <b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> <b>10 YRS.</b> <b>c. LENGTH OF STAY IN 1b</b> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <b>308 WAKEFIELD ROAD</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <b>MARYLAND</b> <b>b. COUNTY</b> <b>WASHINGTON</b> <b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> <b>d. STREET ADDRESS</b> <b>308 WAKEFIELD ROAD</b> <b>e. IS RESIDENCE ON A FARM?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>First Middle Last</b> <b>ROBERT JAMES SPONAUGLE</b> <b>5. SEX</b> <b>MALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>OCT. 12, 1921</b> <b>9. AGE</b> (In years last birthday) <b>44 yrs.</b> <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>MACK TRUCKS</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>CENTRE CO., PENNA.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>						<b>13. FATHER'S NAME</b> <b>FRED J. SPONAUGLE</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>KATHLEEN LIVESAY</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>(If yes give war or dates of service)</b> <b>YES WWII 235-28-3594</b> <b>17. INFORMANT</b> <b>THOMAS S. WHITE, JR. 308 WAKEFIELD ROAD</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Coronary Thrombosis</i> <b>(b)</b> <i>Coronary Atherosclerosis</i> <b>(c)</b> <i>4201</i> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>Hour a.m. p.m.</b> <b>19</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b> <b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>9 Feb</i> , 19 <i>66</i> , to <i>10 Feb</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9 Feb</i> , 19 <i>66</i> , and that death occurred at <i>4 AM</i> , from the causes and on the date stated above. <b>22a. SIGNATURE</b> <i>[Signature]</i> <b>22b. DATE SIGNED</b> <i>2/11/1966</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. DEAN WILSON M.D.</b> <b>22d. ADDRESS</b> <b>580 NORTHERN AVE., HAGERSTOWN, MD.</b> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>23b. DATE THEREOF</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>23d. LOCATION (City, town or county) (State)</b> <b>BURIAL FEB. 12, 1966 ROSE HILL CEMETERY HAGERSTOWN, MARYLAND</b> <b>24. FUNERAL DIRECTOR</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i> <b>HAGERSTOWN, MARYLAND</b> <b>DATE</b> <i>FEB 15 1966</i> <i>[Signature]</i>											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

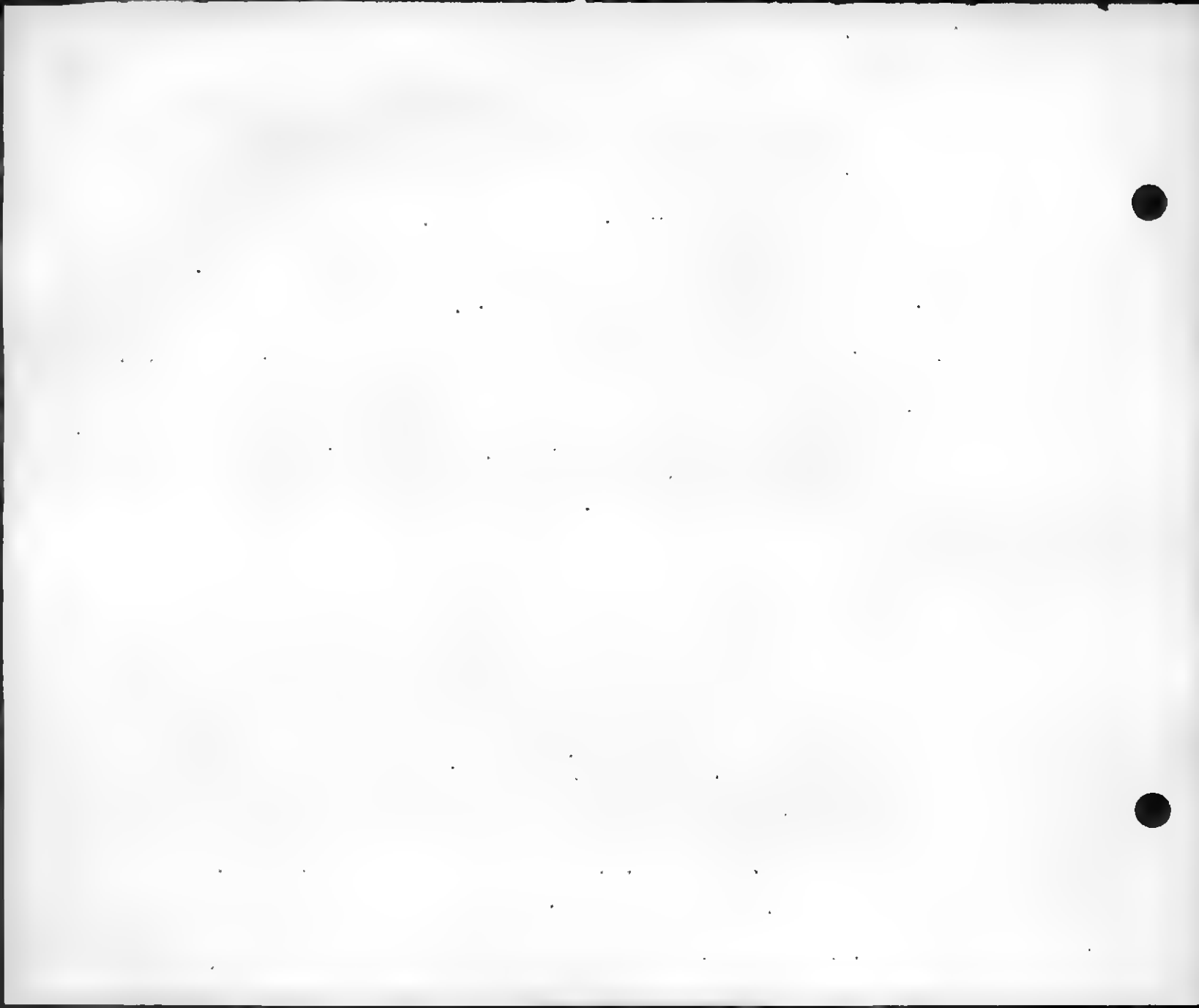
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02941

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WilliamSPORT</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WilliamSPORT</u> d. STREET ADDRESS <u>103. ...</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Reid</u> Last <u>Staley</u>		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27 1915</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Near WilliamSPORT Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ernest Reid</u>	
14. MOTHER'S MAIDEN NAME <u>Olive May Flora</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>015-21-207</u>		17. INFIRMANT <u>Staley Willie</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST &amp; Metastasis</u> <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>19K</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/65</u> , to <u>2/1/66</u> , that (I) (we) last saw the deceased alive on <u>2/1/66</u> , and that death occurred at <u>1A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>2/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>WilliamSPORT, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR <u>Feb 7 1966</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and must be filed within 72 hours after death.

1

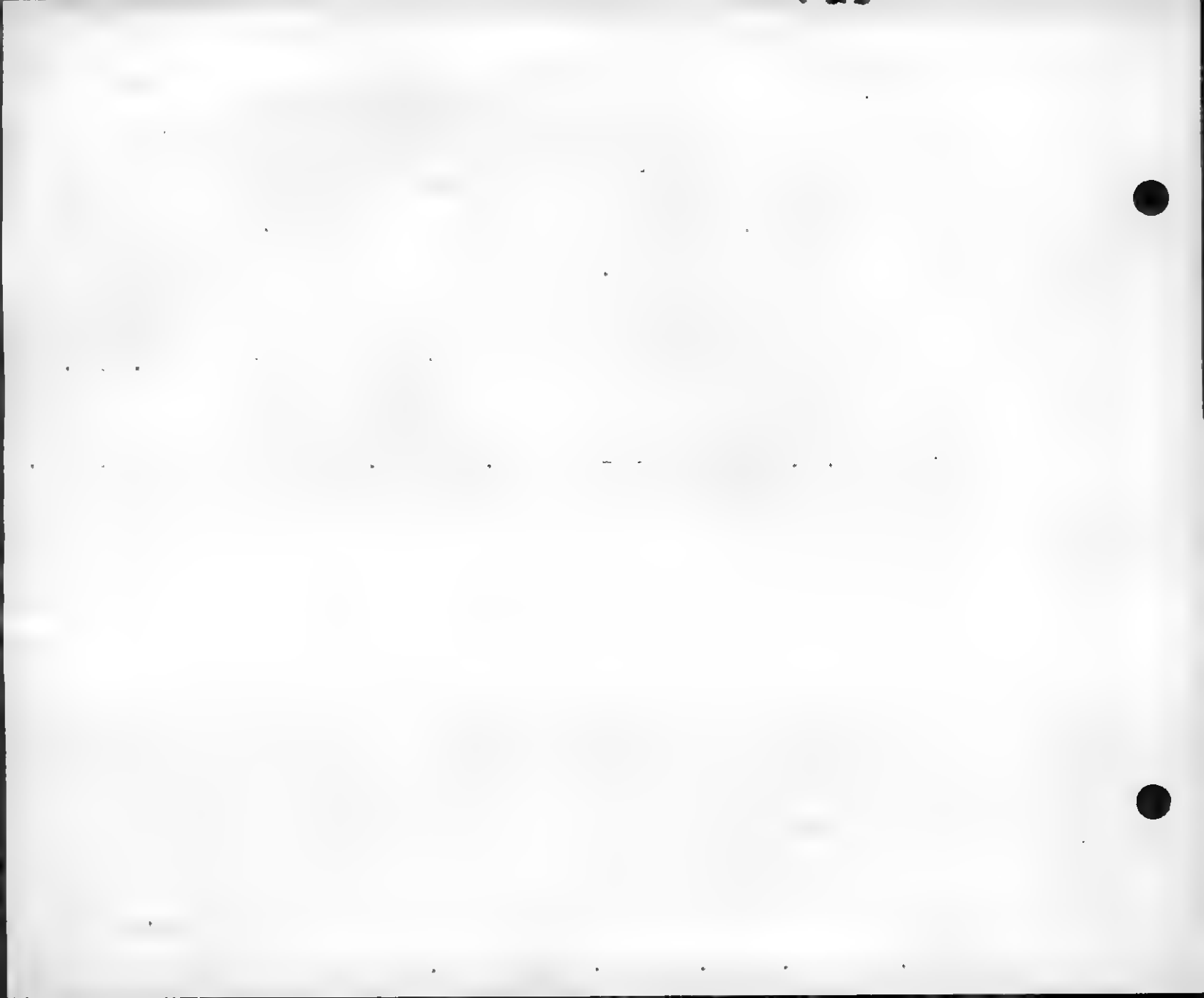
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02961

CERTIFICATE OF DEATH

02942

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Hillsborough</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b>		c LENGTH OF STAY IN 1b <b>16 Months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahrney Keedy Em. Home</b>		d. STREET ADDRESS <b>827 Bayshore Blvd.</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter J. Staley</b>		4. DATE OF DEATH Month Day Year <b>February 5, 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 11, 1891</b>
9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days Hours Min <b>86 24</b>	IF UNDER 24 HRS Hours Min <b>24</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Rural Retreat, Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Pierson Staley</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Snavelly</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W. W. One</b>		16 SOCIAL SECURITY NO <b>181-26-0754</b>	
17. INFORMANT <b>Mrs. Goldie M. Staley, Boonsboro Rfd. 1, Md.</b>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 DUE TO Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to Coronary Arteriosclerosis</b> DUE TO (c) <b>+ Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>Def.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 96 49</b> to <b>Feb 5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5</b> , 19 <b>66</b> , and that death occurred at <b>6:30 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>B B Kneisley</b>		22b. DATE SIGNED <b>Feb 6, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>B B KNEISLEY</b>		22d. ADDRESS <b>1484 Washington St Hagerstown Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>2-8-66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24 FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a REC'D BY REGISTRAR <b>FEB 8 1966</b>	
		25b REGISTRAR'S SIGNATURE <b>Colin L. Jager</b>	



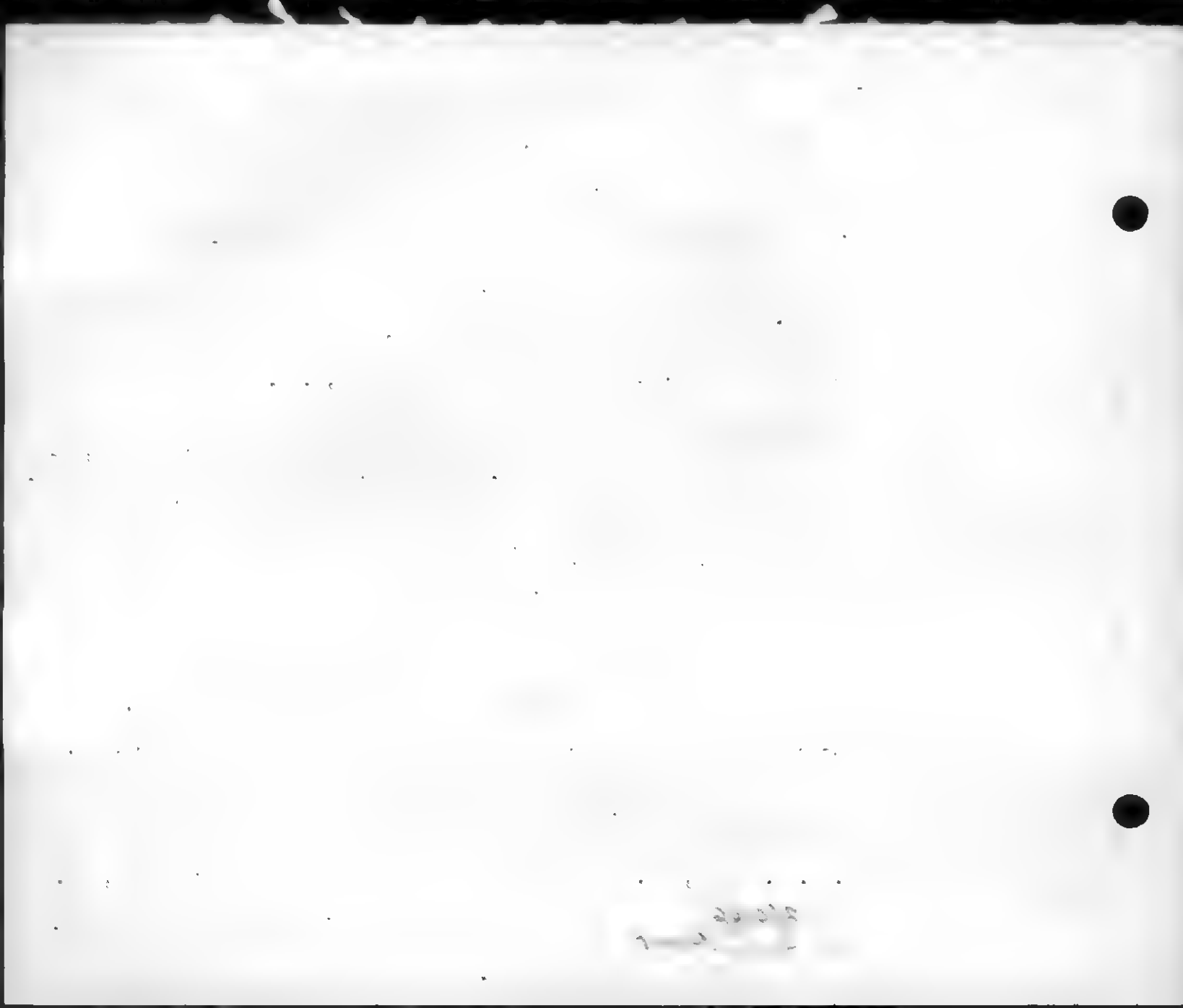
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

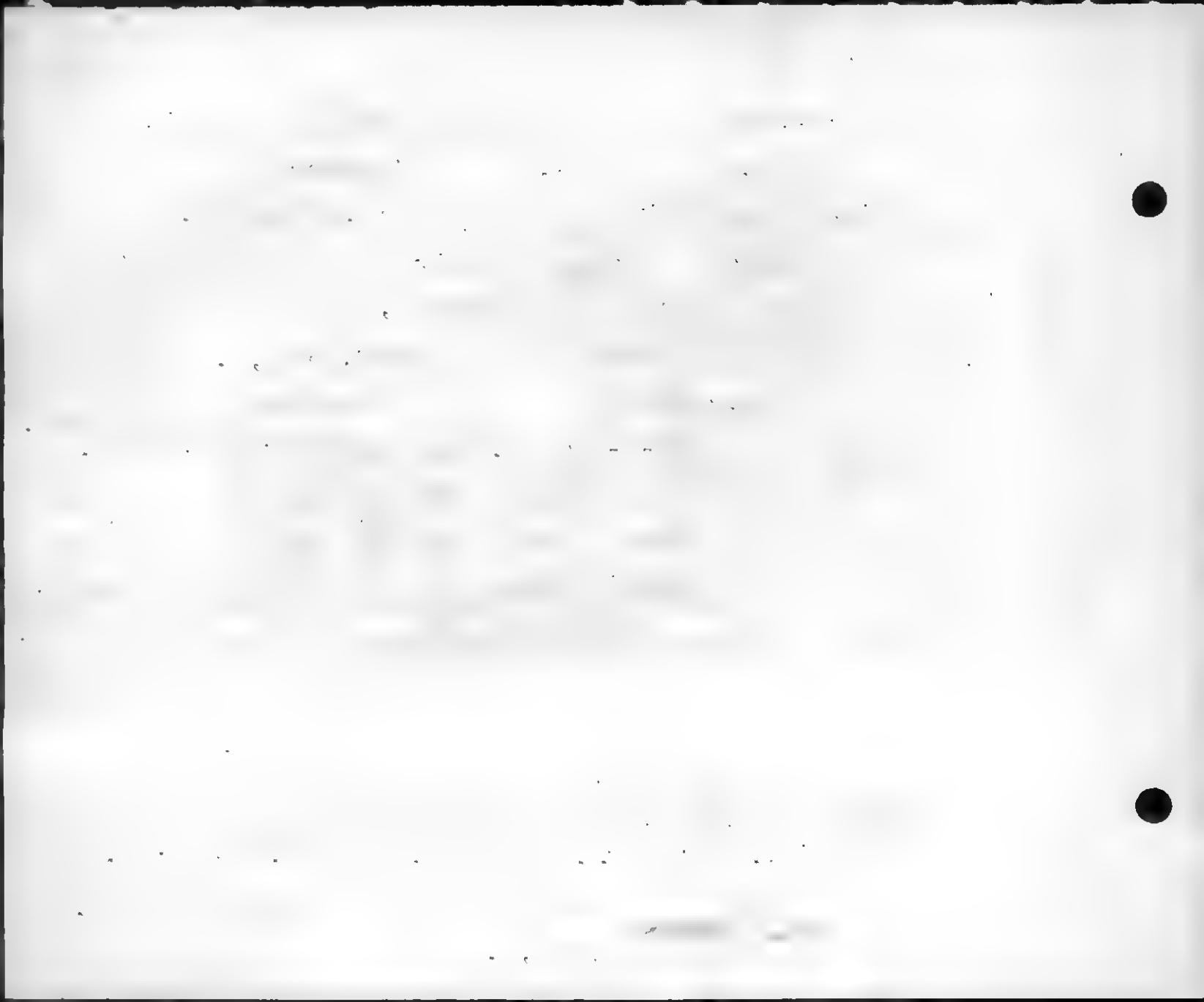
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u> d. STREET ADDRESS <u>105 Stouffer Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sherry</u> Middle <u>Ann</u> Last <u>Stottlemeyer</u>		4. DATE OF DEATH <u>February 1 1/2</u> 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 2, 1950</u> 15 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>	11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u>
13. FATHER'S NAME <u>Cleatys Sherwood Stottlemeyer</u>		14. MOTHER'S MAIDEN NAME <u>Alice Ann Haines</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Alice Ann Stottlemeyer</u>		Address <u>Funkstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Edema, Left Hemothorax</u> DUE TO <u>Status Post Pulmonary Laceration And Right Lower Lobectomy</u> (b) <u>Fractured 5,6,7,8 Ribs &amp; Fracture Of Right Femur</u> (c) <u>Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>While sledding struck by car at street intersection.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>1:30 p.m. 2-1- 19 66</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Funkstown, Washington, Md.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>2-3-66</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/6/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		25a. REC'D BY REGISTRAR <u>Feb 3 1966</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

02263  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02044

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>38 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>36 E. Washington St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Emory</u> Last <u>Strite</u>		4. DATE DEATH <u>February</u> 18 1966	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 22, 1905</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance &amp; Assembly</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Franklin County, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Strite</u>		14. MOTHER'S MAIDEN NAME <u>Rosie McKee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-5084</u>	
17. INFORMANT <u>Mrs. Betty Burger</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor. hemorrhage and heart failure</u> DUE TO (b) <u>Ischemic aortic insufficiency</u> DUE TO (c) <u>Testicular tumor</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>stroke + cerebrovascular insufficiency</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital), attended the deceased from <u>1965</u> to <u>death</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John C. Stauffer</u> 22c. PHYSICIAN'S NAME (Type) <u>John C. Stauffer M.D.</u>		22b. DATE SIGNED M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/21/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (city, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hont</u> <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Wm. C. Hont</u>	

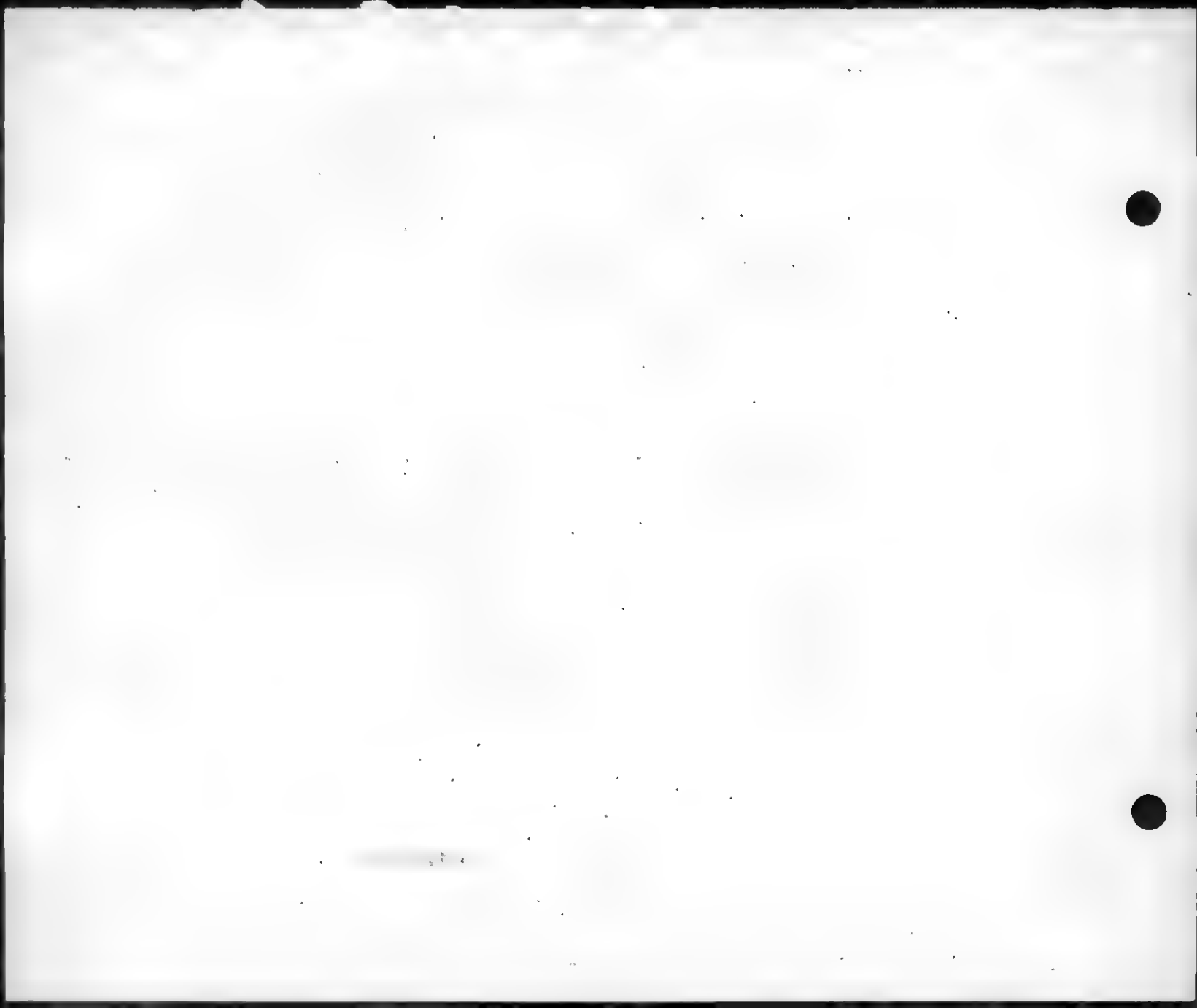


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>23 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>WASHINGTON</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>133 W. FRANKLIN STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>CECILIA VIRGINIA SWITZER</b> <b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>SHOE FACTORY</b>		<b>4. DATE OF DEATH</b> <b>FEBRUARY 13 19 66</b> <b>8. DATE OF BIRTH</b> <b>DEC. 8, 1879</b> <b>9. AGE</b> (In years last birthday) <b>86 yrs.</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>SAMUEL SWITZER</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>MARY J. LAWRENCE</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>214-09-4968</b>		<b>17. INFORMANT</b> <b>WILLIAM H. SWITZER</b> <b>133 W. FRANKLIN ST. HAGERSTOWN, MARYLAND</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Cerebral Thrombosis</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>General Arterio Sclerosis</b> <b>DUE TO (b)</b> <b>DUE TO (c)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 days</b> <b>5 yrs.</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Osteoporosis</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from Feb 6, 1966, to Feb 13, 1966, that (I) last saw the deceased alive on Feb 6, 1966, and that death occurred at 1:30 PM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>J. H. Beachley</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>JACK H. BEACHLEY M.D.</b>				<b>22b. DATE SIGNED</b> <b>2/14/1966</b> <b>ATTENDING PHYS. M.D.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>FEB. 16, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ROSE HILL CEMETERY</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Charles M. Kueper</b>		<b>ADDRESS</b> <b>HAGERSTOWN, MARYLAND</b>		<b>25a. REC'D BY REGISTRAR</b> <b>FEB 21 1966</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			





1  
FOR STATE  
HEALTH DEPT.

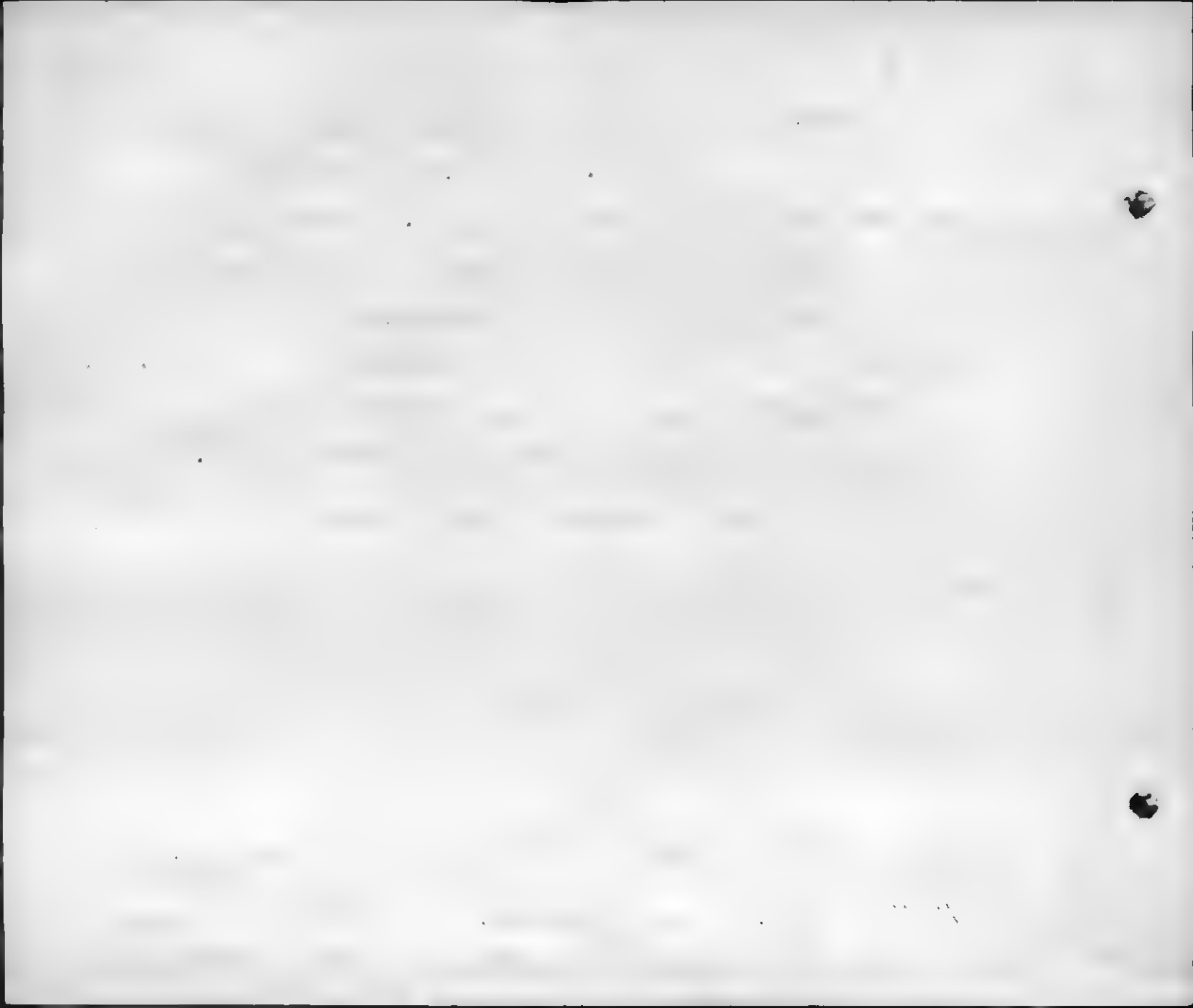
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

02565  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY in 1b <b>1 HR.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BOONSBORO</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>RT. #2 BOONSBORO</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LUCINDA MARIA TRACY</b>		4. DATE OF DEATH <b>FEBRUARY 15 19 66</b>		5. SEX <b>FEMALE</b>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/16/1893</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		9. AGE (In years last birthday) <b>72 yrs.</b>	
13. FATHER'S NAME <b>WILLIAM BAKER</b>		14. MOTHER'S MAIDEN NAME <b>LUCINDA JACKSON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. DAISY SCHMIDT MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Sudden</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/17/66</b>	
EXAMINER'S NAME (Type) <b>Howard N. Weeks, M. D. 580 Northern Ave. Hagerstown, Maryland</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or country) <b>Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/18/66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	
23. FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md.</b>		22d. LOCATION (City, town, or country) (State) <b>HAGERSTOWN MD.</b>		24a. REC'D BY REGISTRAR <b>FEB 21 1966</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

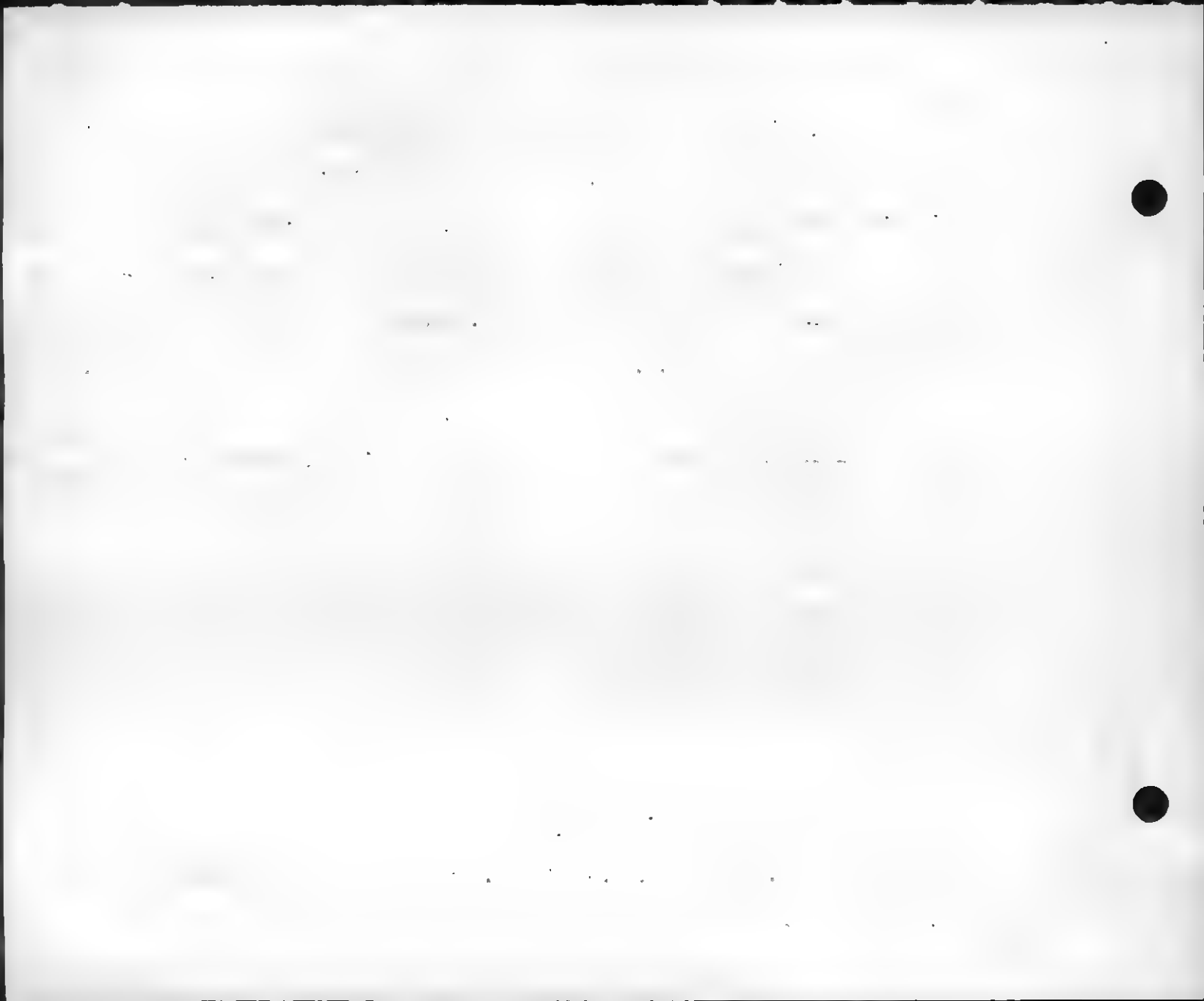


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FOR STATE  
HEALTH DEPT.

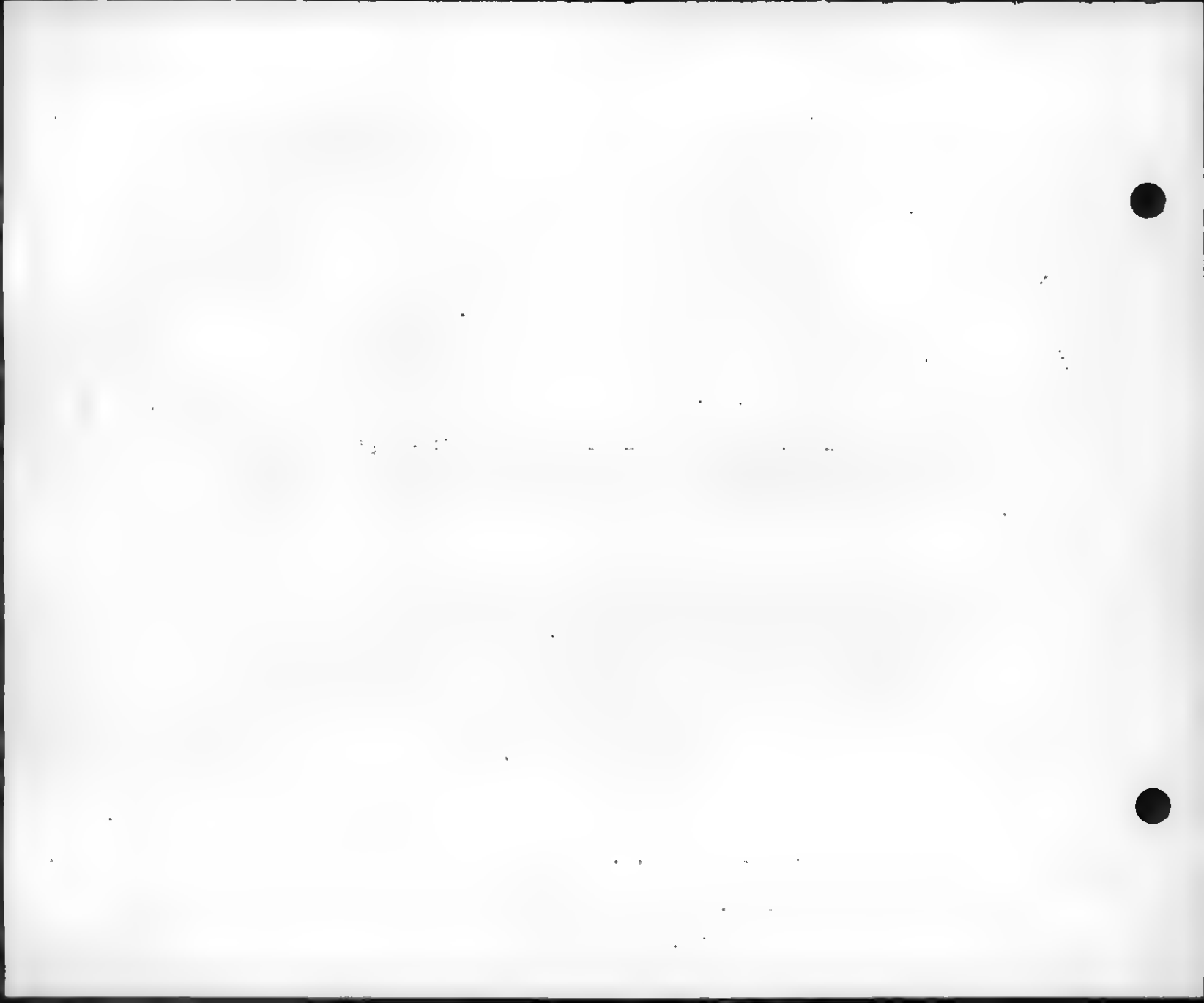
MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>5 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2105 HILLDALE ROAD</b>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>2105 HILLDALE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>MAURINE</b> Middle <b>BARBARA</b> Last <b>UHL</b>					4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>5</b> Year <b>19 66</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 10, 1921</b>		9. AGE (In years last birthday) <b>45 yrs.</b> IF UNDER 1 YEAR: Months <b>45</b> Days <b>19</b> Hours <b>66</b> Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV.</b>		11. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>JOHN KELEHER</b>					14. MOTHER'S MAIDEN NAME <b>ANNE SHIPSEY</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>-----</b>					16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>EDWARD UHL 2105 HILLDALE ROAD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Feb 04/66 / Myocardial fibrosis-Focal, of left</b> DUE TO ventricle and I-V septum - with Focal (b) <b>interstitial myocarditis and small artery</b> DUE TO <b>sclerosis.</b> (c) <b>sclerosis.</b> CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemochromatosis - liver - pancreas - adrenals</b> INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>														
ACTUAL SIGNATURE <b>Edward W. Ditto, Jr.</b> M.D.					22. DATE SIGNED <b>2/7/1966</b>									
EXAMINER'S NAME (Type) <b>EDWARD W. DITTO, JR. M.D. 215 W. WASHINGTON ST. HAGERSTOWN</b>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>FEB. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON, VIRGINIA</b>							
24. FUNERAL DIRECTOR <b>Charles R. Renger</b> ADDRESS <b>HAGERSTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>FEB 11 1966</b> DATE					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02948											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>					c. LENGTH OF STAY IN 1b <b>1 1/2 YRS.</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CLEARVIEW NURSING HOME</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						
					d. STREET ADDRESS <b>1016 CORBETT STREET</b>						
3. NAME OF DECEASED (Type or print) <b>ADA REGINA WAGNER</b>					4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>22</b> Year <b>19 66</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 18, 1874</b>		9. AGE (In years last birthday) <b>91</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FREDERICK CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>IGNATIUS WAGNER</b>					14. MOTHER'S MAIDEN NAME <b>MARY LIVERS WILLIAMSPOTT, MD.</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-22-2484</b>		17. INFORMANT <b>PAUL WAGNER 18 TAMMANY LANE</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstruction of small bowel</b> <b>705</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus &amp; Arteriosclerotic Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 13, 1966</b> to <b>Feb 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 19, 1966</b> , and that death occurred at <b>5:20 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Edwards Moody</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/22/1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>EDSON B. MOODY M.D.</b>					22d. ADDRESS <b>145 S. PROSPECT ST., HAGERSTOWN, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 24, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON CO., MD.</b>					
24. FUNERAL DIRECTOR <b>Charles M. Meyer</b>					ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>in D. Judge</b>		

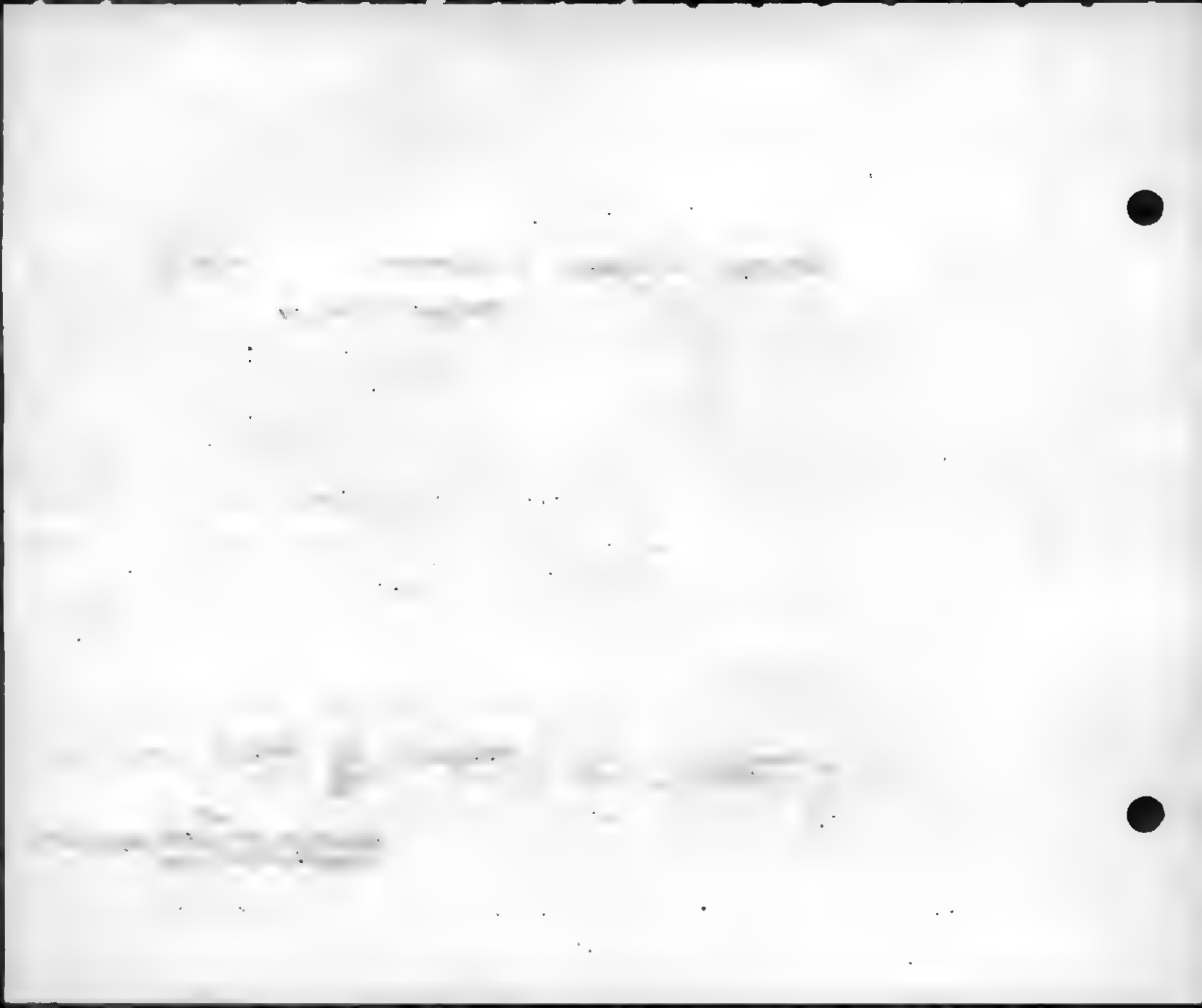


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>		d. STREET ADDRESS <u>503 Lincoln Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>George Kieffer Warman</u>		4. DATE OF DEATH <u>Feb. 7, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1914</u>
9a. AGE (In years last birthday) <u>51</u> yrs.		9b. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B. C. Stremman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Department</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hyattsville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Frank C. Warman</u>		14. MOTHER'S MAIDEN NAME <u>Ida Kieffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ms. Catherine R. Warman (same as #2)</u>	
17. INFORMANT <u>Ms. Catherine R. Warman</u>		Address <u>(same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA LT</u> DUE TO (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CEREBRAL THROMBOSIS</u> <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 WEEK</u> <u>2 1/2 YEARS</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	24. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 13, 1965</u> , to <u>FEB. 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB. 7, 1966</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Efren A. Ramirez</u> M.D.		22b. DATE SIGNED <u>3-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EFREN A. RAMIREZ</u>		22d. ADDRESS <u>Western Md. State Hospital, Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington DC</u>
24. FUNERAL DIRECTOR <u>Sakma Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>3 10 1966</u>	
ADDRESS <u>254 Carroll St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	





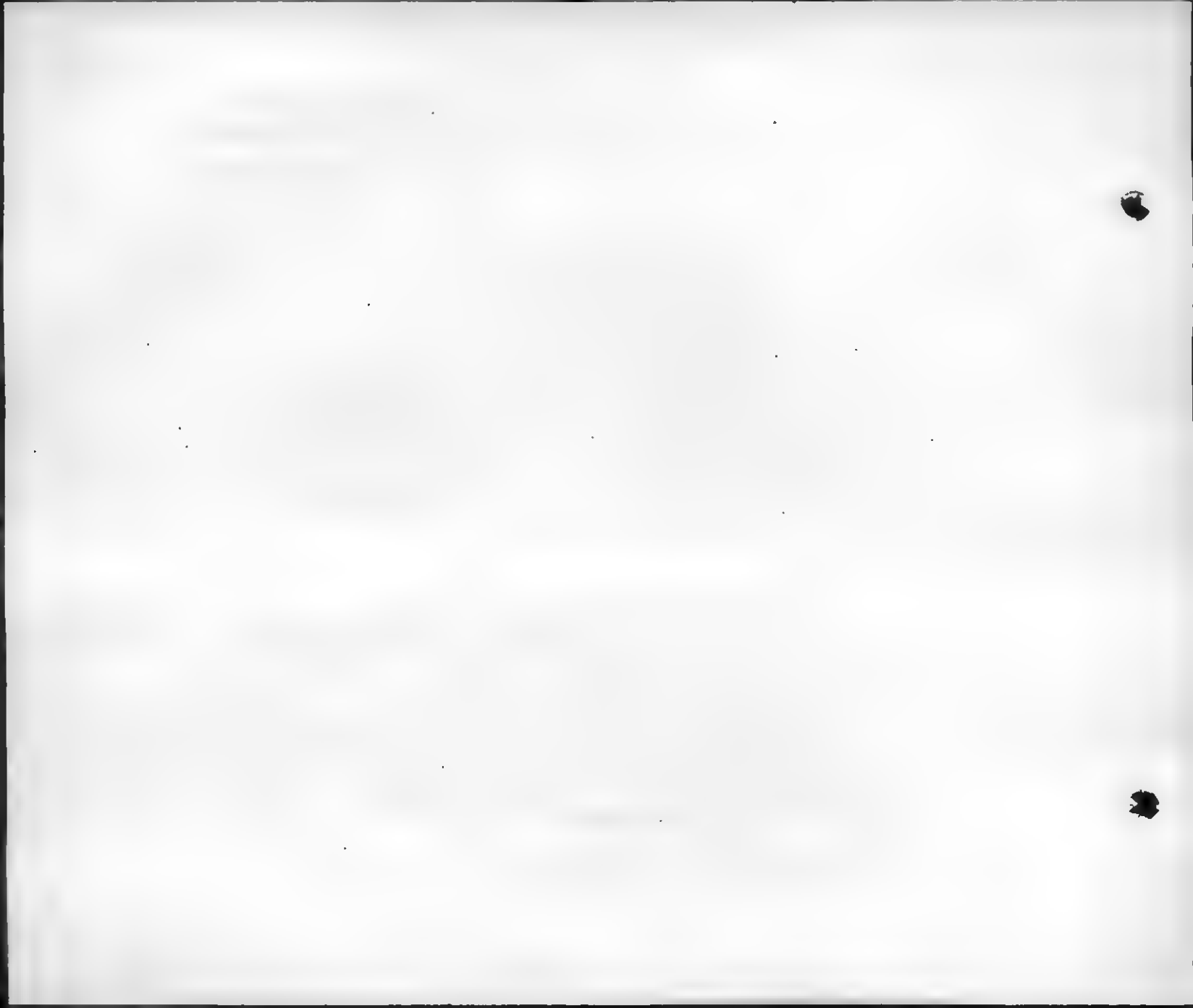
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02869

02950

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>6 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D.# 1 York</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home Inc</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sallie</u> Middle <u>May</u> Last <u>Weigel</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 7, 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>York Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Alice Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>199-07-5730B</u>		17. INFORMANT <u>Mack Wagner Williamsport, Md</u> Address <u>2750 Va Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1412</u> DUE TO <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> 19 <u>66</u> to <u>Feb 13</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 10</u> 19 <u>66</u> , and that death occurred <u>6:20 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Robert P. Conrad</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22a. DATE SIGNED <u>2-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 16 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SHILOH CEMETERY</u>		23d. LOCATION (City town or county) (State) <u>SHILOH IN MIDDLE TWP YORK, PA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Paul - Westminster, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Paul - Westminster</u>	



FOR STATE  
HEALTH DEPT.

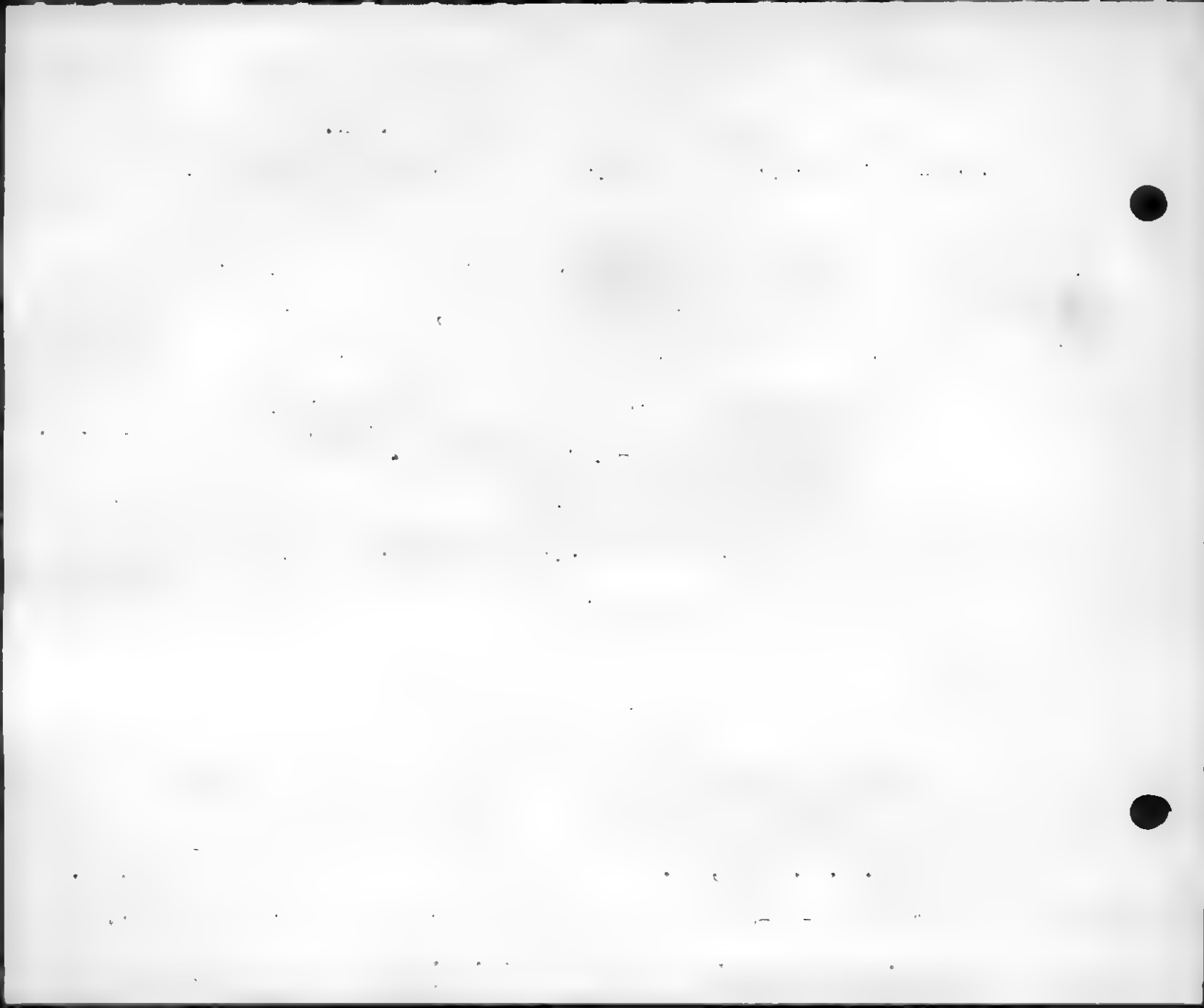
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02951

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Jefferson</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Leitersburg</b>		c. LENGTH OF STAY IN 1b <b>hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural---Kearneysville</b>	
f. STREET ADDRESS <b>RFD # 1</b>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward Taylor Winkler</b>		4. DATE <b>February 11 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>May 23, 1900</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Lee Winkler</b>		14. MOTHER'S MAIDEN NAME <b>Ida Mae Whittington</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>233-34-3519</b>	
17. INFORMANT <b>Rt. 4, Martinsburg, W.Va.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) <b>Coronary Disease</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>4 years</b> <b>4 years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr. E. W. Ditto, Jr.</i>		22. DATE SIGNED <b>2-12-66</b>	
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>2-15-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Charles Town, W. Va.</b>
24. FUNERAL DIRECTOR <b>Melvin T. Strider Co., Charles Town, W. Va.</b>		25a. REC'D BY REGISTRAR <b>DATE 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>E. J. Harris</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute a preliminary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

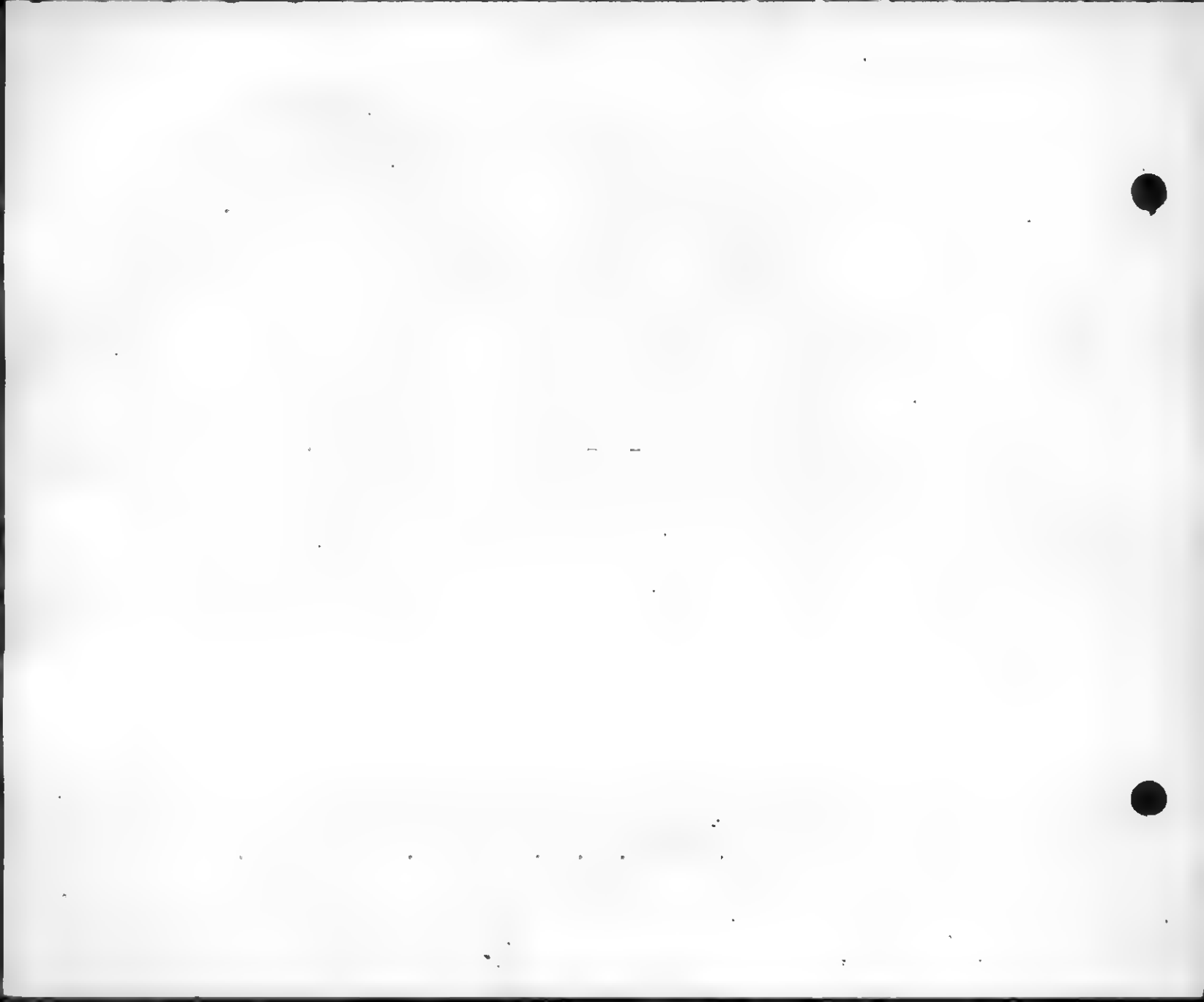


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02971 CERTIFICATE OF DEATH 12952									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN ID <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>2033 VIRGINIA AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ROBERT</b>			First <b>RENO</b>		Middle <b>WOLF</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>8</b> Year <b>1966</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/9/1914</b>		9. AGE (In years last birthday) <b>51</b> yrs. IF FUNER 1 YEAR Months Days IF FUNER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRIC UTILITY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CAROL WOLF</b>					14. MOTHER'S MAIDEN NAME <b>MYRTLE DRILL</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-10-3976</b>		17. INFORMANT <b>MRS PAULINE C. WOLF</b> Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation + inanition</b> DUE TO (b) <b>Bleeding from bronchial carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Disseminated malignant lung cancer</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> , 19 <b>65</b> , to <b>2/8</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>2/7</b> , 19 <b>66</b> and that death occurred at <b>2A</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Thomas V. Craig</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas V. Craig, M. D.</b>						22d. ADDRESS <b>247 N. Potomac St.</b>			
23a. BURIAL, CREMATION, REINTERMENT (Specify)			23b. DATE THEREOF <b>2/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>		
24. FUNERAL DIRECTOR <b>W. J. Horvath, Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02972

CERTIFICATE OF DEATH

02953

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro Rfd. 1</b> 21-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Benevola</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Blanche M. Wyand</b>				4. DATE OF DEATH Month Day Year <b>February 16, 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 19, 1896</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>11 27</b>		IF UNDER 24 HRS. Hours Min. <b>11 27</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rural Sharpsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Albert M. Wyand</b>				14. MOTHER'S MAIDEN NAME <b>Fannie May Burtner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Mrs. George Bowman, Waynesboro, Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4501 Arteriosclerosis with</b> DUE TO (b) <b>gangrene of both legs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>2 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 14</b> , 19 <b>66</b> , to <b>Feb 16</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 16</b> , 19 <b>66</b> , and that death occurred at <b>10</b> P.M. from causes and on the date stated above.							
22a. SIGNATURE <b>G. W. L. L. L.</b>				22b. DATE SIGNED <b>2-18-66</b>		22c. PHYSICIAN'S NAME (Type) <b>G. W. L. L. L.</b>	
22d. ADDRESS <b>Boonsboro, Md.</b>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-19-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Keedysville, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St., Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02973					02954				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Washington</b>					b. COUNTY <b>Washington</b>				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring, Md.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>					d. STREET ADDRESS <b>160 Main St.</b>				
3. NAME OF DECEASED (Type or print) <b>Bessie Ethel Yeakle</b>					4. DATE OF DEATH <b>Feb. 16 1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>		8. DATE OF BIRTH <b>Dec. 21, 1896</b>		9. AGE (In years last birthday) <b>69 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home duties</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Michael OConner</b>					14. MOTHER'S MAIDEN NAME <b>Cora Mullen</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-8882</b>		17. INFORMANT <b>John T. Yeakle</b> Address <b>Clspg. Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of the Myocardium</b> 4201 DUE TO (b) <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Coronary artery atherosclerosis, severe</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus...Hypertensive Heart Disease</b>									INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>  <b>48 hours</b>  <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 11, 1966</b> to <b>Feb 16, 1966</b> , that (I) (we) last saw the deceased alive on <b>February 16, 1966</b> , and that death occurred at <b>4:35 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Archie Robert Cohen</i>					22b. DATE SIGNED <b>Feb 18, 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>					22d. ADDRESS <b>Clear Spring, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/19/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington Co. Md.</b>			
24. FUNERAL DIRECTOR <i>Margaret Rowland</i>		ADDRESS <b>Clear Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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